STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL073022	A. BUILDING: _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ADULT CARE HOME	3067 CHUB LAKE ROAD ROXBORO, NC 27574

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Person County Department of Social Services conducted an initial survey on March 21, 2019.	C 000		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 5 sampled staff (Staff B and Staff D) were competency validated for Licensed Health Professional Support (LHPS) tasks; positioning and emptying a urinary catheter bag and cleaning around the urinary catheter, ambulation using assistive devices that requires physical assistance, application of prescribed heat therapy, inhalation medication by machine, and monitoring of continuous positive air pressure devices (CPAP). The findings are: 1. Review of Staff B medication aide's (MA) personnel record revealed: -There was a hire date of 01/14/19.	C 171		

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C 171	Continued From page 1 -There was no documentation a LHPS competency validation was completed. Interview with Staff B on 03/21/19 at 3:38 pm revealed: -She had worked as a MA at the facility since January 2019. -She provided oral medications, transfer assistance, medications through inhalation and provided assistance with a resident's continuous positive air pressure (CPAP) as needed. -She did not recall completing the LHPS competency validation with a RN. Interview with a resident on 03/21/19 at 9:25 am revealed: -Staff B had assisted her with transferring from the bed to the recliner, assisted with her nebulizer treatments, cleaned her CPAP mask, and assisted with ambulating with her Foley catheter. Refer to interview with the Administrator on 03/21/19 at 5:30 pm. 2. Review of Staff D, medication aide's (MA) personnel record revealed: -There was a hire date of 01/17/19. -There was no documentation a LHPS competency validation was completed. Interview with Staff D on 03/21/19 at 5:06 pm revealed: -She had worked at the facility since January 2019 as a MA. -She performed oral medication administration, assisted with transferring from one area to another and anything else the residents needed. -She did not remember completing a competency validation for LHPS task with anyone at the facility.	C 171		

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C 171	Continued From page 2 -She was trained by the Administrator and the night shift MA at the facility. Interview with a resident on 03/21/19 at 9:25 am revealed: -Staff D had assisted her with transferring with the Foley catheter in place, assisted with her continuous positive air pressure (CPAP) machine and helped her with the walker. Refer to interview with the Administrator on 03/21/19 at 5:30 pm. --- Interview with the Administrator on 03/21/19 at 5:30 pm revealed: -She did the LHPS competency validations for staff and she was a Registered Nurse (RN). -She did not know all staff did not have the LHPS competency validation completed. -She did not know about the different forms for the resident and the staff for LHPS tasks. -She did an audit of the personnel records in February 2019 and did not notice some staff were missing the LHPS competency validation. -She was responsible for ensuring staff had LHPS competency validation completed.	C 171		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	C 330		

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C 330	Continued From page 3 and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 2 of 2 sampled residents (#1 and #2). The findings are: 1. Review of Resident #1's current FL-2 dated 01/08/19 revealed: -Diagnoses included hypothyroidism, chronic right side heart failure, chronic atrial fibrillation, morbid obesity, sleep apnea, and chronic pain. -There was a medication order for oxycontin 30 mg (used to treat pain) twice daily. -There was a medication order for oxycodone 10 mg (used to treat pain) every six hours. -There was a medication order for potassium chloride 20 mcg (used to treat low levels of potassium) three times a day. -There was a medication order for magnesium oxide 400 mg (used to treat low levels of magnesium) three times a day. -There was a medication order for fluoxetine 20 mg (used to treat depression) three times a day. -There was a medication order for furosemide 40 mg (used to treat congestive heart failure, (CHF)) daily. -There was a medication order for levothyroxine 50 mg (used to treat hypothyroidism) daily. -There was a medication order for metolazone 5 mg (used to treat CHF) daily. -There was a medication order for metoprolol tartrate 50 mg (used to treat CHF) twice daily. Review of Resident #1's subsequent orders revealed there was a medication order dated 01/21/19 for levothyroxine 100 mg daily.	C 330		

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C 330	Continued From page 4 Review of Resident #1's January 2019 medication administration record (MAR) revealed: -There was an entry for levothyroxine 100 mg one tablet daily scheduled for administration at 6:00 am. -There was documentation of administration of the levothyroxine 100 mg from 01/23/19 to 01/27/19 at 6:00 am, 01/29/19 at 6:00 am, and 01/31/19 at 6:00 am. -There was no documentation of administration of levothyroxine 100 mg on 01/28/19 and 01/30/19 at 6:00 am. -There was no documentation of a reason for not administering levothyroxine 100 mg on 01/28/19 and 01/30/19 at 6:00 am. -There was an entry for metoprolol tartrate 50 mg one tablet twice daily, scheduled for administration at 6:00 am and 6:00 pm. -There was documentation of administration of metoprolol tartrate 50 mg from 01/01/19 to 01/28/19 at 6:00 am and 6:00 pm, and from 01/30/19 to 01/31/19 at 6:00 am and 6:00 pm. -There was no documentation of administration of metoprolol 50 mg on 01/29/19 at 6:00 pm. -There was no documentation of a reason for not administering metoprolol 50 mg on 01/29/19 at 6:00 pm. -There were three of ninety- three opportunities for administration of medication without documentation on the January 2019 MAR. Review of Resident #1's February 2019 MAR revealed: -There was an entry for oxycontin 30 mg one tablet twice daily, scheduled for administration at 8:00 am and 8:00 pm. -There was documentation of administration of the oxycontin 30 mg from 02/01/19 to 02/04/19 at 8:00 am and 8:00 pm, 02/05/19 at 8:00 am, from	C 330		

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C 330	Continued From page 5 02/06/19 to 02/08/19 at 8:00 am and 8:00 pm, 02/09/19 at 8:00 am, 02/10/19 at 8:00 am, from 02/11/19 to 02/26/19 at 8:00 am and 8:00 pm, 02/27/19 at 8:00 am, and 02/28/19 at 8:00 am and 8:00 pm. -There was no documentation of administration of oxycontin 30 mg on 02/05/19, 02/09/19, 02/10/19, and 02/27/19 at 8:00 pm. -There was no documentation of a reason for not administering oxycontin 30 mg on 02/05/19, 02/09/19, 02/10/19, and 02/27/19 at 8:00 pm. -There was an entry for oxycodone 10 mg one tablet every six hours, scheduled for administration at 6:00 am, 12:00 pm, 6:00 pm, and 12:00 am. -There was documentation of administration of the oxycodone 10 mg from 02/01/19 to 02/15/19 at 6:00 am, 12:00 pm, 6:00 pm, and 12:00 am, 02/16/19 at 6:00 am, 12:00 pm, and 12:00 am, from 02/17/19 to 02/24/19 at 6:00 am, 12:00 pm, 6:00 pm, and 12:00 am, 02/25/19 at 6:00 am, 12:00 pm, and 6:00 pm and from 02/26/19 to 02/28/19 at 6:00 am, 12:00 pm, 6:00 pm, and 12:00 am. -There was no documentation of administration of oxycodone 10 mg on 02/16/19 at 6:00 pm and 02/25/19 at 12:00 am. -There was no documentation of a reason for not administering oxycodone 10 mg on 02/16/19 at 6:00 pm and 02/25/19 at 12:00 am. -There was an entry for potassium chloride 20 meq one tablet three times daily, scheduled for administration at 6:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of potassium chloride 20 meq from 02/01/19 to 02/23/19 at 6:00 am, 12:00 pm, and 6:00 pm, 02/24/19 at 6:00 am and 6:00 pm, and from 02/25/19 to 02/28/19 at 6:00 am, 12:00 pm, and 6:00 pm.	C 330		

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C 330	Continued From page 6 -There was no documentation of administration of potassium chloride 20 meq on 02/24/19 at 12:00 pm. -There was no documentation of a reason for not administering potassium chloride 20 meq on 02/24/19 at 12:00 pm. -There was an entry for magnesium oxide 400 mg one tablet three times daily, scheduled for administration at 6:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of magnesium oxide 400 mg from 02/01/19 to 02/23/19 at 6:00 am, 12:00 pm, and 6:00 pm, 02/24/19 at 6:00 am and 6:00 pm, and from 02/25/19 to 02/28/19 at 6:00 am, 12:00 pm, and 6:00 pm. -There was no documentation of administration of magnesium oxide 400 mg on 02/24/19 at 12:00 pm. -There was no documentation of a reason for not administering magnesium oxide 400 mg on 02/24/19 at 12:00 pm. -There was an entry for fluoxetine 20 mg one tablet three times daily, scheduled for administration at 8:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of fluoxetine 20 mg from 02/01/19 to 02/23/19 at 8:00 am, 12:00 pm, and 6:00 pm, 02/24/19 at 8:00 am and 6:00 pm, and from 02/25/19 to 02/28/19 at 8:00 am, 12:00 pm, and 6:00 pm. -There was no documentation of administration of fluoxetine 20 mg on 02/24/19 at 12:00 pm. -There was no documentation of a reason for not administering fluoxetine 20 mg on 02/24/19 at 12:00 pm. -There was an entry for furosemide 40 mg one tablet daily, scheduled for administration at 8:00 am. -There was documentation of administration of	C 330		

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C 330	Continued From page 7	C 330		

the furosemide 40 mg from 02/01/19 to 02/19/19 at 8:00 am, and from 02/21/19 to 02/28/19 at 8:00 am.
-There was no documentation of administration of furosemide 40 mg for 02/20/19 at 8:00 am.
-There was no documentation of a reason for not administering furosemide 40 mg on 02/20/19 at 8:00 am.
-There was an entry for levothyroxine 100 mg one tablet daily, scheduled for administration at 6:00 am.
-There was documentation of administration of the levothyroxine 100 mg from 02/01/19 to 02/19/19 at 6:00 am, and from 02/21/19 to 02/28/19 at 8:00 am.
-There was no documentation of administration of levothyroxine 100 mg on 02/20/19 at 6:00 am.
-There was no documentation of a reason for not administering levothyroxine 100 mg on 02/20/19 at 6:00 am.
-There was an entry for metolazone 5 mg one tablet daily, scheduled for administration at 6:30 am.
-There was documentation of administration of the metolazone 5 mg from 02/01/19 to 02/19/19 at 6:30 am, and from 02/21/19 to 02/28/19 at 6:30 am.
-There was no documentation of administration of metolazone 5 mg on 02/20/19 at 6:30 am.
-There was no documentation of a reason for not administering metolazone 5 mg on 02/20/19 at 6:30 am.
-There was an entry for metoprolol tartrate 50 mg one tablet twice daily, scheduled for administration at 6:00 am and 6:00 pm.
-There was documentation of administration of metoprolol tartrate 50 mg from 02/01/19 to 02/09/19 at 6:00 am and 6:00 pm, 02/10/19 at 6:00 am, 02/11/19 at 6:00 am and 6:00 pm, 02/12/19 at 6:00 am, from 02/13/19 to 02/26/19 at

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C 330	Continued From page 8 6:00 am and 6:00 pm, 02/27/19 at 6:00 am and 02/28/19 at 6:00 am and 6:00 pm. -There was no documentation of administration of metoprolol 50 mg on 02/10/19, 02/12/19, and 02/27/19 at 6:00 pm. -There was no documentation of a reason for not administering metoprolol 50 mg on 02/10/19, 02/12/19, and 02/27/19 at 6:00 pm. -There were fifteen of five hundred and twenty four opportunities for medication administration on the February 2019 MAR without documentation of administration. Observation of Resident #1's medication on hand on 03/21/19 at 12:15 pm revealed: -There was one box with oxycodone and oxycontin in alternating packets available for administration. -There was a box with packets containing all Resident #1's am medications except oxycodone and oxycontin. -There was a box with packets containing the 12:00 pm tablets. -There was a box with packets containing the 6:00 pm tablets. -There was potassium chloride, magnesium oxide, fluoxetine, furosemide, levothyroxine, metolazone, and metoprolol tartrate available for administration. Interview with Resident #1 on 03/21/19 at 4:10 pm revealed: -She received her medications without any difficulty. -The staff brought the medications in her room to administer. -She did not recall any missed doses of medication. Refer to interview with second shift MA on	C 330		

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C 330	Continued From page 9 03/21/19 at 5:06 pm. Refer to interview with the Administrator on 03/21/19 at 5:30 pm. 2. Review of Resident #2's current FL-2 dated 12/01/18 revealed: -Diagnoses included weakness, hypertensive chronic kidney disease stage III, anemia, dementia, hyperlipidemia, carotid atherosclerosis, and poly-neuropathy. -There was a medication order for oxybutynin 5 mg (used to treat overactive bladder) one tablet twice daily. -There was a medication order for donepezil 10 mg (used to treat dementia) one tablet twice daily. -There was a medication order for vitamin C 500 mg (used to treat vitamin C deficiency) daily. -There was a medication order for ferrous sulfate 325 mg (used to treat iron deficiency) daily. Review of Resident #2's subsequent physician orders revealed a medication order for probiotic two tablets daily. Review of Resident #2's January 2019 medication administration record (MAR) revealed: -There was an entry for oxybutynin 5 mg one tablet twice daily, scheduled for administration at 8:00 am and 6:00 pm. -There was documentation of administration of the oxybutynin 5 mg 01/01/19 at 8:00 am, from 01/02/19 to 01/18/19 at 8:00 am and 6:00 pm, 01/19/19 at 8:00 am, from 01/20/19 to 01/28/19 at 8:00 am and 6:00 pm, 01/29/19 at 8:00 am, and from 01/30/19 to 01/31/19 at 8:00 am and 6:00 pm. -There was no documentation of administration of oxybutynin 5 mg on 01/01/19, 01/19/19 and	C 330		

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C 330	Continued From page 10 01/29/19 at 6:00 pm. -There was no documentation of a reason for not administering oxybutynin 5 mg on 01/01/19, 01/19/19 and 01/29/19 at 6:00 pm. -There was an entry for donepezil 5 mg one tablet twice daily, scheduled for administration at 8:00 am and 6:00 pm. -There was documentation of administration of donepezil 5 mg 01/01/19 at 8:00 am, from 01/02/19 to 01/28/19 at 8:00 am and 6:00 pm, 01/29/19 at 8:00 am, and from 01/30/19 to 01/31/19 at 8:00 am and 6:00 pm. -There was no documentation of administration of donepezil 5 mg on 01/01/19 and 01/29/19 at 6:00 pm. -There was no documentation of a reason for not administering donepezil 5 mg on 01/01/19 and 01/29/19 at 6:00 pm. -There was an entry for vitamin C 500 mg one tablet three times daily with iron, scheduled for administration at 8:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of vitamin C 500 mg from 01/01/19 to 01/28/19 at 8:00 am, 12:00 pm, and 6:00 pm, 01/29/19 at 8:00 am and 12:00 pm, and from 01/30/19 to 01/31/19 at 8:00 am, 12:00 pm, and 6:00 pm. -There was no documentation of administration of vitamin C 500 mg on 01/29/19 6:00 pm. -There was no documentation of a reason for not administering vitamin C 500 mg on 01/29/19 6:00 pm. -There was an entry for ferrous sulfate 325 mg one tablet three times daily with vitamin C 500 mg, scheduled for administration at 8:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of ferrous sulfate 325 mg from 01/01/19 to 01/28/19 at 8:00 am, 12:00 pm, and 6:00 pm, 01/29/19 at 8:00 am and 12:00 pm, and from 01/30/19 to	C 330		

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C 330	Continued From page 11 01/31/19 at 8:00 am, 12:00 pm, and 6:00 pm. -There was no documentation of administration of ferrous sulfate 325 mg on 01/29/19 6:00 pm. -There was no documentation of a reason for not administering ferrous sulfate 325 mg on 01/29/19 6:00 pm. -There were seven of three hundred and ten opportunities for medication administration on the January 2019 MAR without documentation of administration. Review of Resident #2's February 2019 medication administration record (MAR) revealed: -There was an entry for oxybutynin 5 mg one tablet twice daily, scheduled for administration at 8:00 am and 6:00 pm. -There was documentation of administration of the oxybutynin 5 mg from 02/01/19 to 02/16/19 at 8:00 am and 6:00 pm, 02/17/19 at 8:00 am, and from 02/18/19 to 02/28/19 at 8:00 am and 6:00 pm. -There was no documentation of administration of oxybutynin 5 mg on 02/17/19 at 6:00 pm. -There was no documentation of a reason for not administering oxybutynin 5 mg on 02/17/19 at 6:00 pm. -There was an entry for donepezil 5 mg one tablet twice daily, scheduled for administration at 8:00 am and 6:00 pm. -There was documentation of administration of donepezil 5 mg from 02/01/19 to 02/16/19 at 8:00 am and 6:00 pm, 02/17/19 at 8:00 am, and from 02/18/19 to 02/28/19 at 8:00 am and 6:00 pm. -There was no documentation of administration of donepezil 5 mg on 02/17/19 at 6:00 pm. -There was no documentation of a reason for not administering donepezil 5 mg on 02/17/19 at 6:00 pm. -There was an entry for vitamin C 500 mg one tablet three times daily with iron, scheduled for	C 330		

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HELPING HANDS ADULT CARE HOME	3067 CHUB LAKE ROAD ROXBORO, NC 27574

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 12 administration at 8:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of vitamin C 500 mg from 02/01/19 at 8:00 am, 12:00 pm, and 6:00 pm, 02/02/19 at 8:00 am, 12:00 pm, and 6:00 pm, from 02/03/19 to 02/16/19 at 8:00 am, 12:00 pm, and 6:00 pm, 02/17/19 at 8:00 am and 12:00 pm, from 02/18/19 to 02/23/19 at 8:00 am, 12:00 pm, and 6:00 pm, 02/24/19 at 8:00 am and 6:00 pm, and from 02/25/19 to 02/28/19 at 8:00 am, 12:00 pm, and 6:00 pm. -There was no documentation of administration of vitamin C 500 mg on 02/02/19 and 02/17/19 at 6:00 pm and 02/24/19 at 12:00 pm. -There was no documentation of a reason for not administering vitamin C 500 mg on 02/02/19 and 02/17/19 at 6:00 pm and 02/24/19 at 12:00 pm. -There was an entry for ferrous sulfate 325 mg one tablet three times daily with vitamin C 500 mg, scheduled for administration at 8:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of ferrous sulfate 325 mg from 02/01/19 to 02/16/19 at 6:00 am, 12:00 pm, and 6:00 pm, 02/17/19 at 6:00 am and 12:00 pm, from 02/18/19 to 02/23/19 at 6:00 am, 12:00 pm, and 6:00 pm, 02/24/19 at 8:00 am and 6:00 pm, and from 02/25/19 to 02/28/19 at 8:00 am, 12:00 pm and 6:00 pm. -There was no documentation of administration of ferrous sulfate 325 mg on 02/17/19 at 6:00 pm and 02/24/19 12:00 pm. -There was no documentation of a reason for not administering ferrous sulfate 325 mg on 02/17/19 at 6:00 pm and 02/24/19 12:00 pm. -There were seven of two hundred and fifty-six opportunities for medication administration on the February 2019 MAR without documentation of administration.	C 330		

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C 330	Continued From page 13 Review of Resident #2's March 2019 medication administration record (MAR) revealed: -There was an entry for vitamin C 500 mg one tablet three times daily with iron, scheduled for administration at 8:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of vitamin C 500 mg from 03/01/19 to 03/18/19 at 8:00 am, 12:00 pm, and 6:00 pm, 03/19/19 at 8:00 am and 6:00 pm, 03/20/19 at 8:00 am, 12:00 pm, and 6:00 pm, and 03/21/19 at 8:00 am and 12:00 pm. -There was no documentation of administration of vitamin C 500 mg on 03/19/19 at 12:00 pm. -There was no documentation of a reason for not administering vitamin C 500 mg on 03/19/19 at 12:00 pm. -There was an entry for ferrous sulfate 325 mg one tablet three times daily with vitamin C 500 mg, scheduled for administration at 8:00 am, 12:00 pm and 6:00 pm. -There was documentation of administration of ferrous sulfate 325 mg from 03/01/19 to 03/18/19 at 8:00 am, 12:00 pm, and 6:00 pm, 03/19/19 at 8:00 am and 6:00 pm, 03/20/19 at 8:00 am, 12:00 pm, and 6:00 pm, and from 03/21/19 at 8:00 am, and 12:00 pm. -There was no documentation of administration of ferrous sulfate 325 mg on 03/19/19 at 12:00 pm. -There was no documentation of a reason for not administering ferrous sulfate 325 mg on 03/19/19 at 12:00 pm. -There was an entry for probiotic gummies take two gummies daily, scheduled for 8:00 am. -There was documentation of administration of probiotic gummies from 03/01/19 to 03/15/19 at 8:00 am, and from 03/17/19 to 03/21/19 at 8:00 am. -There was no documentation of administration of probiotic gummies on 03/16/19 at 8:00 am.	C 330		

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C 330	Continued From page 14 -There was no documentation of a reason for not administering probiotic gummies on 03/16/19 at 8:00 am. -There were three of one hundred twenty-seven opportunities for medication administration on the March 2019 MAR without documentation of administration. Observation of Resident #2's medication on hand on 03/21/19 at 1:23 pm revealed there were oxybutynin 5 mg, ferrous sulfate 325 mg, probiotic gummies, vitamin C 500 mg, and donepezil 10 mg available for administration. Interview with Resident #2 03/21/19 at 3:25 pm revealed: -Her family did take her out of the facility for outings sometimes. -She had not been absent from the facility on 01/01/19, 01/19/19, 01/29/19, 02/02/19, 02/17/19, 02/24/19, 03/16/19, and 03/19/19. -She did not recall any missing dosages of medications. Refer to interview with second shift MA on 03/21/19 at 5:06 pm. Refer to interview with the Administrator on 03/21/19 at 5:30 pm. Interview with the second shift MA on 03/21/19 at 5:06 pm revealed: -She worked second shift at the facility from 4:00 pm to 11:00 pm. -She reviewed and signed the MARs when she administered medications. -She did not audit the MARs at the end of the month for accuracy. -She did not know residents' MARs had incomplete documentation of administration.	C 330		

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C 330	Continued From page 15 -She may have become distracted by requests to do other things for residents and did not sign off the medications. -She did administer all the physician ordered medications to the residents. Interview with the Administrator on 03/21/19 at 5:30 pm revealed: -She did not audit the MARs and she did not know there were opportunities for medication administration in January 2019, February 2019 and March 2019 without documentation of administration. -She was not able to verify with documentation the administration of all the medication for residents for the dates indicated. -She assigned auditing the MARs to the day shift MA who would check to ensure all physician ordered medications were on the MAR and documentation of administration was on the MARs daily.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration;	C 342		

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C 342	Continued From page 16 (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the medication administration records (MARS)were accurate and complete for 2 of 2 sampled residents (#1, and #2) with orders for a short acting bronchodilator and a vitamin supplement. The findings are: 1. Review of Resident #1's current FL-2 dated 01/08/19 revealed: -Diagnoses included hypothyroidism, chronic right side heart failure, chronic atrial fibrillation, morbid obesity, sleep apnea, and chronic pain. -There was a medication order for albuterol sulfate 2.5 mg (used to treat asthma) nebulizer every 4 to 6 hours as needed for shortness of breath. Review of Resident #1's physician's office visit clinical summary dated 03/13/19 revealed there was an entry for albuterol sulfate 2.5 mg /3ml nebulizer every 4 to 6 hours as needed for shortness of breath on the current medication list. Review of Resident #1's January 2019, February 2019, and March 2019 medication administration records (MARs) revealed there were no entries for albuterol sulfate 2.5mg/3ml nebulizers.	C 342		

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C 342	Continued From page 17 Observation of Resident #1's medication on hand on 03/21/19 at 12:15 pm revealed there was one opened box of plastic vials of albuterol sulfate 2.5 mg/3ml available for administration. Interview with Resident #1 on 03/21/19 at 4:10 pm revealed: -The nebulizer machine remained in her room. -She knew how to operate the nebulizer machine. -The staff provided the medication to place into the nebulizer. -She requested the medication when needed and the last time she requested and needed a nebulizer was a couple of weeks ago. Interview with the medication aide (MA) on 03/21/19 at 3:38 pm revealed: -The pharmacy had sent albuterol sulfate for Resident #1 to the facility and it was in the Administrator's office. -She had administered a nebulizer to Resident #1 but could not recall the last date. -When she administered the nebulizer to Resident #1 she documented it on the MAR. -She did not know the albuterol sulfate was not entered on the January 2019, February 2019, and March 2019 MARs. -She did not know a reason why the albuterol sulfate was not entered on the January 2019, February 2019 and March 2019 MARs. -The Administrator entered any changes in medication orders on the MAR. -She was assigned by the Administrator to audit the MARs daily and checked for missed documentation of administration. -She started auditing the MARs in March but did not note the albuterol sulfate was not listed on the March MAR. -She thought if it was a medication not given often it was not placed on the MAR.	C 342		

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C 342	Continued From page 18 Interview with the medical assistant at Resident #1's physician's office on 03/21/19 at 2:40 pm revealed: -Resident #1's last physician office visit was 03/13/19. -There was documentation in the computer system the date of the last prescription written for albuterol sulfate 2.5 mg/3 ml was 03/13/19 with twelve refills. -Prescriptions were sent to the pharmacy via electronic prescriptions during office visits. -The physician completed the FL-2s for Resident #1 and the physician's office was supposed to keep one on record but she was unable to locate the most current FL-2 for Resident #1. -There was no documentation of a discontinue order for albuterol sulfate 2.5 mg/3 ml in the computer system. Telephone interview with the contracted pharmacy on 03/21/19 at 2:17 pm revealed: -The albuterol was last dispensed on 03/13/19 for an amount of 60 vials. -There was no documentation in the computer system indicating the facility staff contacted the pharmacy about the albuterol sulfate. -The last order date within the computer system for albuterol was 03/13/19. -Medication refills for the facility were done by cycle refill, except for as needed medications and controlled substances. -The pharmacy did use FL-2s for orders when sent to the pharmacy. -There was no documentation in the computer system indicating a FL-2 was received for Resident #1. Interview with the Administrator on 03/21/19 at 5:25 pm revealed:	C 342		

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C 342	Continued From page 19 -She was responsible for medication orders and whoever received the medication orders placed the order on the MARs. -She took residents and attended the residents' physician office visits. -The physician's orders were faxed over to the pharmacy from the physician's office. -She did not know why the albuterol sulfate was not on the MARs. -The MAs were supposed to document the administration of all medications on the MAR. -The albuterol sulfate was on Resident #1's FL-2 dated 01/08/19. -She was responsible for ensuring medications were administered as ordered by the physician. -She did not have any documentation of administration of albuterol sulfate for Resident #1. 2. Review of Resident #2's current FL-2 dated 12/01/18 revealed: -Diagnoses included weakness, hypertensive chronic kidney disease stage III, anemia, dementia, hyperlipidemia, carotid atherosclerosis, and poly-neuropathy. -There was an order for vitamin B12 1000 mcg (used to treat vitamin B12 deficiency) daily. Review of Resident #2's January 2019 medication administration records (MARs) revealed there was no entry for vitamin B12 5000 mcg daily. Review of Resident #2's February 2019 MARs revealed: -There was an entry for vitamin B12 5000 mcg daily, scheduled for 8:00 am. -Vitamin B12 5000 mcg was documented as administered at 8:00 am from 02/01/19 to 02/28/19.	C 342		

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C 342	Continued From page 20 Review of Resident #2's March 2019 MARs revealed: -There was an entry for vitamin B12 5000 mcg daily, scheduled for 8:00 am. -Vitamin B12 5000 mcg was documented as administered at 8:00 am from 03/01/19 to 03/21/19. Observation of Resident #2's medication on hand on 03/21/19 at 1:23 pm revealed there was an over the counter bottle of vitamin B12 2500 mcg available for administration. Interview with Resident #2 on 03/21/19 at 3:25 pm revealed: -She took vitamin B12 every day. -She did not know why she took vitamin B12. -Her family did not provide her medications, but her family paid for the medications purchased by the Administrator. Telephone interview with the contracted pharmacy on 03/21/19 at 2:17 pm revealed: -There was documentation in the computer system of a vitamin B12 5000 mcg order dated 09/07/18 with a note written on the side to place on the February 2019 MAR for Resident #2. -The pharmacy had not dispensed any vitamin B12 for Resident #2 and the vitamin was to be purchased over the counter. -The facility staff faxed the order over to the pharmacy in January 2019 and on 03/21/19. Attempted interview with Resident #2's physician on 03/21/19 at 1:20 pm was unsuccessful. Interview with the medication aide (MA) on 03/21/19 at 4:07 pm revealed: -The Administrator took Resident #2 to the physician and would be the one familiar with her	C 342		

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C 342	Continued From page 21 medication orders in January 2019. -She did not know the vitamin B12 was not documented on Resident #2's January 2019 MAR. -The last date she administered the vitamin B12 was on 03/21/19. - She administered the dose of vitamin B12 entered on the MAR, 5000 mcg. Interview with the Administrator on 03/21/19 at 5:25 pm revealed: -She expected the staff to administer medications as ordered. -She did not know the vitamin B12 was not entered on the January 2019 MAR. -She thought the vitamin B12 1000 mcg dose was written incorrectly on Resident #2's FL-2 dated 12/01/18 and the correct dose for the vitamin B12 was 5000 mcg. -She thought the vitamin B12 5000 mcg was administered to Resident #2 but she did not have any documentation of the administration for January 2019. -She did not know the bottle of vitamin B12 available for administration were 2500 mcg tablets and did not match the physician's order for 5000 mcg. -She did not know if the staff were administering one or two tablets to Resident #2.	C 342		
C 420	10A NCAC 13G .1201 (6) Resident Records 10A NCAC 13G .1201Resident Records (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;	C 420		

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C 420	Continued From page 22 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to assure physician's orders for blood pressure monitoring for 2 of 2 sampled residents (#1 and #2) were implemented and documented . The findings are: 1. Review of Resident #1's current FL-2 dated 01/08/19 revealed: -Diagnoses included hypothyroidism, chronic right side heart failure, chronic atrial fibrillation, morbid obesity, sleep apnea, and chronic pain. -There was an order for blood pressure monitoring once a week. Review of Resident #1's physician orders dated 01/08/19 revealed there was an order for blood pressure monitoring monthly and this order was signed after the FL-2 order. Review of Resident #1's vital signs flow sheet revealed: -There was no entry for the blood pressure monitoring physician's order. -There was documentation of a blood pressure reading on 01/20/19 of 90/53, 03/09/19 of 122/65, and 03/15/19 of 102/60. -There was no documentation of a blood pressure reading for February 2019. Interview with Resident #1 on 03/21/19 at 4:10 pm revealed: -The staff took her blood pressure every now and then, maybe monthly. -She had her own blood pressure machine and checked her blood pressure frequently, possibly every other day or when she felt like it needed to	C 420		

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C 420	Continued From page 23 be checked. -She did not ask the staff to check it when she felt like it needed to be checked because she could do it with her blood pressure machine. -She did not report the blood pressure readings when she took her own blood pressure. -She did not recall the specific date in February but believed the staff took her blood pressure within the month of February 2019. Interview with the day shift medication aide (MA) on 03/21/19 at 3:38 pm revealed: -She knew how to take a blood pressure measurement, but did not take a blood pressure measurement for Resident #1 within the month of February 2019. -The facility had a blood pressure machine to use for resident blood pressure monitoring. -The second shift staff did the blood pressure monitoring in February 2019. -Blood pressure measurements were documented on the vital sign flow sheet and not the medication administration record. -She thought the blood pressure order for Resident #1 was to monitor the blood pressure monthly. Interview with the second shift MA on 03/21/19 at 5:17 pm revealed: -Resident #1's blood pressure was monitored monthly. -She obtained a blood pressure reading for Resident #1 last week and documented it on the vital sign flow sheet. -She did take resident #1's blood pressure in February 2019. -She did not know what happened in February 2019, but she may have become distracted with another task or a resident may have asked her for something.	C 420		

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C 420	Continued From page 24 Interview with Resident #1's physician's medical assistant on 03/21/19 at 2:40 pm revealed resident #1 was to have blood pressure monitored monthly by the facility staff. Interview with the Administrator on 02/07/19 at 5:00 pm revealed: -Resident #1's blood pressure monitoring was done by the MAs. -She thought Resident #1's blood pressure monitoring was done as ordered by the physician. -She did not audit the vital sign flow sheet to determine if Resident #1's blood pressure was done as ordered by the physician monthly. -She did not have any documentation of Resident #1's February 2019 blood pressure reading. -She was responsible for ensuring physician orders were followed. 2. Review of Resident #2's current FL-2 dated 12/01/18 revealed: -Diagnoses included weakness, hypertensive chronic kidney disease stage III, anemia, dementia, hyperlipidemia, carotid atherosclerosis, and poly-neuropathy. -There was an order for blood pressure monitoring daily. Review of Resident #2's subsequent physician orders dated 02/25/19 revealed there was an order for blood pressure monitoring weekly. Review of Resident #2's January 2019 medication administration record (MAR) revealed: -There was a handwritten entry for daily blood pressure reading scheduled at 8:00 am. -There was documentation the blood pressure reading was completed from 01/01/19 to 01/30/19 at 8:00 am, but no blood pressure readings were	C 420		

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	FCL073022	A. BUILDING: _____ B. WING _____	03/21/2019

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HELPING HANDS ADULT CARE HOME	3067 CHUB LAKE ROAD ROXBORO, NC 27574

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 420	Continued From page 25 documented only staff initials. Review of Resident #2's vital sign flow sheet revealed: -There was no entry for the blood pressure monitoring physician order. -There was no documentation of blood pressure readings for February 2019. -There was documentation of blood pressure readings for 03/09/19 and 03/16/19. Interview with Resident #2 on 03/21/19 at 3:25 pm revealed the staff did take her blood pressure, she did not know how often. Attempted interview with Resident #2's physician on 03/21/19 at 1:20 pm was unsuccessful. Interview with the second shift MA on 03/21/19 at 5:17 pm revealed: -She checked Resident #2's blood pressure "last week". -If the February 2019 blood pressure readings for Resident #2 were not on her vital sign flow sheet, she may have forgotten to document them. Interview with the Administrator on 03/21/19 at 5:25 pm revealed: -She did not have any documentation of Resident #2's blood pressure readings for February 2019. -She did not know why Resident #2's blood pressure readings were not documented as done.	C 420		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	C935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C935	Continued From page 26 (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by:	C935		

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C935	Continued From page 27 Based on interviews and record reviews, the facility failed to assure 1 of 5 sampled staff (Staff B) who administered medications had completed the additional 10 hour medication administration training program within 60 days from the date of hire. The findings are: Review of Staff B, medication aide's (MA), personnel record revealed: -Staff B's hire date was 01/14/19. -There was documentation Staff B passed the medication aide test on 08/01/00. -There was documentation Staff B completed the 5-hour medication training on 04/28/18. -There was documentation Staff B completed the medication clinical skills validation checklist on 01/15/19. -There was no documentation that Staff B worked as a MA at another facility in the past 24 months. -There was no documentation of the 10 hour medication administration training. Interview with Staff B on 03/21/19 at 3:38 pm revealed: -She had recently completed all of her training locally. -She thought she had completed the 10 hour medication administration training program but the certificate provided to her was for the 5 hour medication administration training program. Interview with a resident on 03/21/19 at 4:10 pm revealed: -Staff B administered her medications. -Staff B last administered her medications on 03/21/19. Review of a resident's Medication Administration	C935		

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C935	Continued From page 28 Records (MARs) for January 2019, February 2019 and March 2019 revealed: -There was documentation Staff B administered medications on 01/14/19, 01/16/19, 01/21/19, 02/02/19, 02/11/19, 03/02/19, and 03/20/19. Interview with the Administrator on 03/21/19 at 5:30 pm revealed: -Staff B administered medications. -She thought Staff B had completed all of the MA training on 02/20/19. -She did not know about the 10 hour medication training had to be done within 60 days from the date of hire. -She was responsible for ensuring completed the 10 hour medication training program within 60 days of hire.	C935		