STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033004	A. BUILDING: _____ B. WING _____	R 04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE HOME #2	1101 HILL STREET ROCKY MOUNT, NC 27801

(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 conducted an annual and a follow-up survey on 04/14/21.	C 000		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	C 335		

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C 335	Continued From page 1	C 335		

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination for 4 of 4 residents (#1, #2, #3, and #4).

The findings are:

Observation of a small cardboard box on 04/14/21 at 10:37am revealed:
-The cardboard box was square and had several dark-colored stains at the bottom of the box.
-The cardboard box had a lid that did not lock and was easily removed
-There were five stacks of plastic medication cups that contained medications in each cup.
-There were four stacks that had four medication cups stacked one upon the other.
-There was one stack that had two medication cups stacked one upon the other.
-There was one cup that contained one medication that was white and round.
-There was one cup that contained five medications that were white and yellow.
-There was one cup that contained six medications that were white and contained one small yellow medication.
-There was one cup that contained three medications that were white and contained one red pill.
-There was one cup that contained a few medications that were white and contained yellow medications.

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C 335	Continued From page 2 Interview with the Supervisor in Charge (SIC) on 04/14/21 at 10:26am revealed: -She prepared medications and controlled substances three days in advance for all residents' to "save time". -She put the medications in small medication cups with no label of the resident's first name, medication name, medication dosage, date, or times of day. -She did not label the medication cups because she knew what each residents' medications "looked like". -She put the medication cups stacked one upon the other in a small cardboard box under her bed in her room. -None of the cups were sealed to prevent contamination. -She stored Resident #1, Resident #2, Resident #3, and Resident #4's medication in the same cardboard box. -The cardboard box was not a lockable fire-proof safe box. Interview with the Administrator on 04/14/21 at 11:11am revealed: -Resident's medications were supposed to be stored under "lock and key". -She was not aware that the SIC stored prepared medications under her bed in a cardboard box. -She was not aware that the medications prepared in advance were not sealed to prevent contamination. -She expected all medications to be stored in the medication storage unit. -She last provided training on medication administration at the beginning of the year. -She could not remember the last time she checked the resident's medications.	C 335		

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C 335	Continued From page 3 Interview with a Pharmacy Technician from the facility contracted pharmacy on 04/14/21 at 12:00pm revealed: -Pre-poured medications should be stored in separate containers with the resident's name on it. -The residents could be administered the wrong medications if the pre-poured medications were not labeled with the resident name.	C 335		
C 353	10A NCAC 13G .1006(b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure all residents' medications were maintained safely under locked security. The findings are: Review of the Medication Storage policy for the facility revealed: -Locked rooms and carts for the security of all drugs with appropriate accountability records. -Separate storage for "internal and external" drugs. -Keys for medication carts and controlled drugs are always kept with the person in charge of the cart (supervisor in charge/medication aide) during	C 353		

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C 353	Continued From page 4 the shift in which they were scheduled to work. Observations on 04/14/21 at 8:28am revealed: -There was a room to the right of the front entrance, with the door opened. -There was a large box on the bed that contained several disposable bags in it. -Two residents sat in the hallway to the left of the room near the front entrance. Interview with the Supervisor in Charge (SIC) on 04/14/21 at 10:26am revealed: -Her room was the room that was located to the right of the front entrance of the facility. -The large box on her bed contained all the resident's medications in separate disposable bags. -She kept the medications in her room because it "saved time". Observation of the SIC room from 8:28am to 10:20am revealed: -The door to her room remained open. -No residents attempted to go into her room. -The SIC was not in her room. Interview with a Pharmacy Technician from the facility contracted pharmacy on 04/14/21 at 12:00pm revealed: -Non-controlled medications should be stored in a locked cart in the facility. -She would have a concern that a resident would get a hold of medications if they were not locked and secured. -The resident could take the wrong medication. Interview with the Administrator on 04/14/21 at 11:11am revealed: -All medications were supposed to be kept in the medication storage unit.	C 353		

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C 353	Continued From page 5 -She always expected the medication storage unit to be locked. -She was not aware that the SIC stored the residents' medications in her room. -She delivered the residents' medications to the facility at the beginning of the month. -She expected the SIC to separate the medications by resident name and store the medications in the resident's individual plastic medication storage bucket. -She did not remember the last time she checked to assure the SIC was storing medications appropriately. -She was last at the facility on Tuesday but she did not look at medications.	C 353		
C 368	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure controlled medication for 2 of 2 sampled residents (#2 and #4) with orders for an anti-anxiety medication were stored under a double lock. The findings are: 1. Review of Resident #2's FL-2 dated 09/30/20 revealed:	C 368		

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C 368	Continued From page 6 -Diagnoses included paranoid schizophrenia and hypertension. -There was an order for lorazepam (a medication used to treat anxiety) 1mg two times a day. (Lorazepam is a federally controlled substance (C-IV) because it can be abused or lead to dependence). Observation of Resident #2's medication on hand on 04/14/21 at 10:45am revealed Resident #2's Lorazepam was stored with all the resident's medication in a cardboard box that did not have a lock. Refer to interview with the Supervisor in Charge (SIC) on 04/14/21 at 10:26am. Refer to interview with a Pharmacy Technician from the facility contracted pharmacy on 04/14/21 at 12:00pm. Refer to interview with the Administrator on 04/14/21 at 11:11am. 2. Review of Resident #4's FL-2 dated 09/30/20 revealed: -Diagnoses included mild mental retardation, schizophrenia, and hypertension. -There was an order for lorazepam (a medication used to treat anxiety) 0.5mg two times a day. (Lorazepam is a federally controlled substance (C-IV) because it can be abused or lead to dependence). Observation of Resident #4's medication on hand on 04/14/21 at 11:00am revealed Resident #4's Lorazepam was stored with all the resident's medication in a cardboard box that did not have a lock.	C 368		

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C 368	Continued From page 7 Refer to interview with the Supervisor in Charge (SIC) on 04/14/21 at 10:26am. Refer to interview with a Pharmacy Technician from the facility contracted pharmacy on 04/14/21 at 12:00pm. Refer to interview with the Administrator on 04/14/21 at 11:11am. _____ Interview with the Supervisor in Charge (SIC) on 04/14/21 at 10:26am revealed: -She was aware that controlled medications were supposed to be stored in the locked medication storage unit. -She kept the medications in her room because it "saved time". Interview with a Pharmacy Technician from the facility contracted pharmacy on 04/14/21 at 12:00pm revealed: -Controlled substances should be stored in a locked cart in a separate box locked. -She would have a concern that a resident would get a hold of medications if they were not locked and secured. Interview with the Administrator on 04/14/21 at 11:11am revealed: -She was aware that controlled substances were supposed to be kept under double lock. -She expected the SIC to store controlled substances under double-lock. -She was not aware that the SIC kept the controlled substances in her room unsecured and not locked. -She had separate locked boxes for each resident to store their controlled substances. -She did not remember the last time she saw the locked boxes.	C 368		

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C 368	Continued From page 8 -The locked boxes were supposed to be kept in the locked medication storage unit. -She was concerned that the residents in the facility could easily access the controlled substances and take them.	C 368		