Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	R 04/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(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 Follow-up Survey on 04/07/21.	C 000		
C 230	10A NCAC 13G .0801(a) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed for 1 of 3 sampled residents (#2) within 72 hours of the residents' admission to the facility. The findings are: Review of Resident #2's current FL2 dated 03/25/21 revealed: -Diagnoses included stage 5 renal failure, sleep apnea, allergic rhinitis, diverticulitis, schizophrenia, diastolic heart failure, depression, history of constipation, history of gastroesophageal reflux disease, hypertension, and hyperlipidemia. -The FL2 had an admission date of 03/31/21 for the current facilty. Review of Resident #2's record reveal there was no Resident Register available for review. Review of Resident #2's March 2021 medication administration record (MAR) revealed a staff documented the administration of medication beginning on 03/31/21.	C 230		

Received and Accepted with Addendums to the POC on p.2, p.4, and p.10. Keisha Banks 05/20/21

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C 230	Continued From page 1 Interview with Resident #2 on 04/06/21 at 3:15pm revealed: -She was admitted to the facility a week ago. -She was her own responsible party and did not complete and sign a Resident Register since her admission to the facility. -She was administered medications, provided meals, showered, and slept at the facility. Interview with the Administrator on 04/06/21 at 3:17pm revealed: -He was responsible for ensuring Resident Registers were completed for residents within 72 hours of admission to the facility. -He knew the Resident Register was supposed to be completed within 72 hours of admission for new residents. -He must have overlooked getting the Resident Register completed and signed.	C 230	Resident #2's friend was moving out of state, and was frantically looking for a place for her to stay. When a bed was offered, the move was rushed, hence the resident register was overlooked. This is an unfortunate event which will not occur again. The Resident register has since been completed and signed by resident #2. This was done on 4/8/2021.	
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 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 by a licensed prescribing practitioner for 1 of 3 sampled residents related to	C 330	The Administrator will ensure the Resident Register is completed within the first 3 days of admission for new residents. Completion Date: 04/08/21 KB 05/20/21	

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C 330	Continued From page 2 a diuretic medication. The findings are: Review of Resident #2's current FL2 dated 03/25/21 revealed: -Resident #2 was admitted to the facility on 03/31/21. -Diagnoses included stage 5 renal failure, diastolic heart failure, hypertension, and hyperlipidemia. -There was an order for Lasix 80mg (used to treat fluid retention) 1 tablet twice daily at 8:00am and 12:00pm on non dialysis days (Sunday, Tuesday, Wednesday, Thursday, and Saturday). Review of Resident #3's medication administration record (MAR) for March 2021 revealed: -There was a handwritten entry for Lasix 80mg, but there were no instructions for administration. -In the frequency column on the MAR, as needed was documented. Review of Resident #3's MAR for April 2021 revealed: -There was an entry for Lasix 80mg take 1 tablet twice daily at 8:00am and 12:00pm on non dialysis days. -In the frequency column on the MAR, as needed was documented. -There was no documentation Lasix was administered for 10 of 10 opportunities at 8:00am and 12:00pm from 04/01/21 through 04/07/21. Observation of Resident #2's medications on hand on 04/07/21 at 4:15pm revealed there was no Lasix 80mg available for administration. Telephone interview with a pharmacist from the	C 330	This error was done by the Pharmacy. Unfortunately, it was not picked up by the care home either. The administrator will personally compare medication orders to the MAR's to make sure everything is where its supposed to be. This check will	

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C 330	Continued From page 3 facility's contracted pharmacy on 04/07/21 at 3:39pm revealed: -There was an active order on file for Resident #2 for Lasix 80mg 1 tablet twice daily at 8:00am and 12:00pm on non dialysis days. -The order for Lasix was a scheduled order and not an as needed order although it was located on the wrong page of the MAR and that may have been why Lasix was not automatically dispensed to the facility. -Lasix 80mg would normally be automatically dispensed to the facility, but the pharmacy had only repackaged medication for Resident #2 as she had medication from her previous facility. -Lasix 80mg was not repackaged and had not been dispensed to the facility. -Once MARs were printed, the MARS were delivered to the facilty for review and the facility could enter a medication or request a change on the MAR. -No one from the facilty had requested Lasix 80mg for Resident #2 or requested a change to the MAR. Interview with Resident #2 on 04/07/21 at 3:52pm revealed: -She was admitted to the facility about a week ago. -She went to dialysis on Mondays and Fridays. -She was supposed to take Lasix 80mg on her non dialysis days, but she had not been administered Lasix since she had been at the current facility. -Lasix helped her to urinate and she had not urinated as much since she had been administered Lasix. -She asked for Lasix, but she was told by staff Lasix was an as needed medication. Interview with a personal care aide (PCA) on	C 330	be conducted at least twice per week. Documentation of this will be made in the resident's folder. The Administrator will be responsible for checking medication received from the pharmacy and comparing the medications to the MARs to ensure accuracy. The Administrator will ensure all medications have been received from the pharmacy and are available for administration to residents. The Administrator will check MARs received from the pharmcy every 30 days and when there is a new MAR requested from the pharmacy due to a significant change in medications. Completion Date: 04/08/21 KB 05/20/21	

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C 330	Continued From page 4 04/07/21 at 4:17pm revealed: -Resident #2 requested Lasix, but she told her the pharmacy did not send Lasix for her. -She had not told the Administrator Lasix was not available in the facility for Resident #2. Interview with the Administrator on 04/07/21 at 3:51pm revealed: -Resident #2's Lasix was ordered for twice daily on non dialysis days. -He thought Lasix should have been administered as needed because as needed was documented in the frequency column on the MAR and was on the as needed medication page of the MAR. -He did not know Lasix 80mg was not available in the facility for administration. -He was responsible for reviewing the MARs and comparing the MARs to the medication orders when the MARs were delivered from the pharmacy. -He did not review Resident #2's April 2021 MAR for medication accuracy when it was delivered to the facility. Interview with Resident #2's primary care provider (PCP) on 04/07/21 at 4:02pm revealed: -Resident #2 had an order for Lasix 80mg twice daily on non dialysis days and Lasix was a scheduled medication. -Lasix was a diuretic and was prescribed for Resident #2 to pull fluid out of her body tissue. -He did not know the facility considered Resident #2's Lasix an as needed medication and he did not know the facilty had not administered Lasix to Resident #2 since she was admitted to the facility. -Not administering Lasix to Resident #2 as ordered could result in Resident #2 gaining fluid volume and possible electrolyte imbalance. -He did not have any concerns with Resident #2	C 330		

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C 330	Continued From page 5 missing 5 days (10 doses) of Lasix administration in April 2021 because dialysis should have been able to make up for any fluid not extracted when Lasix was not administered during the 5 days, but the facilty needed to start administering Lasix to Resident #2 as ordered as soon as possible.	C 330		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related Adult Care Home Medication Aides: Training and Competency. The findings are: Based on interviews, and record reviews, the facility failed to ensure 2 of 4 sampled staff (Staff A and D) who administered medications to residents had completed the medication competency clinical skills validation checklist, the 5, 10, or 15 hour state approved medication administration training courses, and successfully passed the written medication examination within 60 days of beginning duties of medication administration. [Refer to Tag 935, G.S. 131D-4.5(B)(b) Adult Care Home Medication Aides: Training and Competency (Type B	C 912		

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C 912	Continued From page 6 Violation).]	C 912		
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. (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	C935		

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C935	Continued From page 7 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: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to ensure 2 of 4 sampled staff (Staff A and D) who administered medications to residents had completed the medication competency clinical skills validation checklist, the 5, 10, or 15 hour state approved medication administration training courses, and successfully passed the written medication examination within 60 days of beginning duties of medication administration. The findings are: 1. Review Staff B's, personal care aide (PCA), personnel record revealed: -Staff B was hired on 06/29/18. -There was documentation a medication clinical skills competency validation was completed 06/29/19. -There was documentation a 15 hour medication training was completed on 11/21/19. -There was no documentation Staff B passed the written medication examination. Review of a written medication examination form provided by the Administrator revealed Staff B	C935		

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C935	Continued From page 8 took the examination on 06/19/19 and failed. Review of Medication Administration Records (MAR) of 3 residents for March 2021 and April 2021 revealed: -Staff B documented administering medication for 10 days in March 2021. -Staff B documented administering medication for 7 days in April 2021. Interview with Staff B on 04/07/21 at 9:47am revealed: -She worked from 7:00am to 7:00am the next day. -On the days when she worked a medication aide (MA) came in at 8:00pm to administer medication and a MA or the Administrator came on duty in the morning and afternoon to administer medication. -She administered medication to residents this morning and documented administration. -A MA pre-filled medication cups and left them for her to administer to residents. -She just started administering medications to residents within the last week or 2. -The Administrator usually came in to administer afternoon medications and any as needed medications to residents. -She had a 2 hour medication training with the facility contracted nurse, but she did not remember when. -She did not remember having a 5, 10, or 15 hour training and she had not taken the written medication aide test. -She did not know she needed to take the 5, 10, or 15 hour medication training hours and medication clinical skills validation checklist prior to passing medication and pass the written medication examination within 60 days of completing the medication clinical skills validation	C935		

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C935	Continued From page 9 checklist. A second interview with Staff B on 04/07/21 at 2:20pm revealed: -She did not tell the truth about the MA pre-filling medication cups. -She made statements earlier in the day on 04/07/21 because she did not know what to say. -She administered medication to residents on her own. -She knew there was a time window of an hour before an an hour after to administer medication and most of the time there was not a MA there to administer medication so she went ahead and administered the medication to stay within the time window. -She had not called the Administrator to come and administer the medication. -She took the written medication aide test in 2019 and did not pass it. Interview with 3 residents on 04/07/21 at 3:13pm revealed: -Staff B administered medications when she worked. -Staff B administered scheduled and as needed medications. -A MA came in the evening to administer the evening medications. Interview with the Administrator on 04/07/21 at 10:23am revealed: -He did not know Staff B was administering medications to residents. -He thought a MA was coming in the morning to administer medications. -Staff B completed her medication clinical skills competency validation checklist, her 5, 10, or 15 hour medication administration course, but she did not pass her medication examination within	C935	Staff B received a write up for what occured. As of 4/8/21, she was not administering medication in any way. Only staff qualified to administer medication have been performing this all important duty since 4/8/21. The Administrator will review staff records to ensure all staff who administer medication have completed the 5, 10, or 15-hour training, the medication clinical skills validation, and passed the written medication aide examination within 60 days of beginning duties of medication administration. Completion Date: 04/08/21 KB 05/20/21	

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C935	Continued From page 10 60 days of the clinical skills validation. -The facility contracted Registered Nurse (RN) provided the medication training. -Staff B should not have administered medication because she did not pass the written medication examination. Attempted telephone interview with the facility's contracted RN on 04/07/21 at 10:28am and 1:53pm were unsuccessful. 2. Review Staff D's, personal care aide (PCA) personnel record revealed: -There was no documentation of a hire date provided. -There was documentation a medication clinical skills competency validation checklist was completed on 03/12/21. -There was documentation a 15 hour medication training was completed on 03/12/21. -There was no documentation Staff D passed the written medication examination. Attempted telephone interview with Staff D on 04/07/21 at 4:59pm was unsuccessful. Review of Medication Administration Records (MAR) of 3 residents for February 2021 and March 2021 revealed: -Staff D documented she administered medication for 5 days in February 2021. -Staff D documented she administered medication for 7 days between 03/01/21 and 03/12/21. Interview with the Administrator on 04/07/21 at 10:23am revealed: -Staff D was hired on 03/12/21. -Staff should not administer medications until they have taken the 5,10, or 15 hour medication	C935		

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C935	Continued From page 11 course, completed the medication clinical skills validation checklist, and passed the written medication examination within 60 days of the completing the medication clinical skills validation checklist. Attempted telephone interviews with the facility's contracted Registered Nurse (RN) on 04/07/21 at 10:28am and 1:53pm were unsuccessful. The facility failed to ensure 2 of 4 sampled staff (Staff B and Staff C) who were administering medications had completed the 5, 10, or 15 hour medication training, were competency validated, and passed the written medication examination within 60 days which increased the risk of medication errors. This failure was detrimental to the health, safety and welfare or the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/07/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, MAY 22, 2021.	C935	The health, safety and welfare of our residents are our priority at all times. We take pride in making sure they are well taken care of when it comes to their meals, and medication. Going forward, the 60 day rule for passing the NC Medication Tech exam shall be strongly adhered to. All new hires will complete the 5, 10 or 15 hour medication training, and pass the written exam within 60 days. This will eliminate the probability of medication errors. Documentation will be available in staff records. This violation is deemed corrected as of 04/08/2021.	