STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL096009	A. BUILDING: _____ B. WING _____	R 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANTHAM FAMILY CARE # II	107 N GEORGIA AVENUE GOLDSBORO, NC 27530

(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 05/27/21.	C 000		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the walls in the residents' bathrooms were kept clean and in good repair. The findings are: Observation of the residents' bathroom on 05/27/21 at 11:12am revealed: -There were multiple areas of peeling paint with exposed dry wall. -There was an area, at least two feet by two feet, of peeling and curled paint and exposed dry wall. -There was an area of peeling paint, greater than six inches, at the intersection of the shower frame and the wood rail next to the bathtub. -There was a small area of peeling paint and exposed dry wall above the toilet. -The paint on the door frame was extensively peeling. -There was bubbling and peeling paint under the	C 074		

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C 074	Continued From page 1	C 074		

doorknob.
-There were spider webs on the inside upper corners of the window.
-There was peeling paint and black and gray mold on the window frame.
-There was gray mold along the wood trim at the intersection of the wall and ceiling above the shower.
-There was an area of black spotted mold, at least three feet long, along the wall above the door.

Interview with the Supervisor-in-Charge (SIC) on 05/27/21 at 11:12am revealed:
-She spoke with an electrician about installing an exhaust fan to correct the excess moisture problem that was causing the paint to peel.
-After the exhaust fan was installed, the bathroom would be repainted.

Telephone interview with the electrician on 05/27/21 at 3:45pm revealed:
-There was excess moisture in the bathroom that was causing the paint to peel.
-He talked with the SIC on 05/26/21 and they had a verbal agreement to install an exhaust fan in the bathroom.
-He was in the process of finding the right exhaust fan for the bathroom.

Interview with the SIC on 05/27/21 at 5:25pm revealed:
-Someone previously painted the residents' bathroom.
-The painter used flat paint and that was the reason the paint was peeling and did not hold up against the moisture.
-She and the electrician had a verbal agreement for installation of an exhaust fan for the bathroom.
-She did not have a written estimate or contract

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C 074	Continued From page 2 from the electrician. Interview with the Administrator on 05/27/21 at 5:45pm revealed: -The wrong type of paint was used on the bathroom walls. -An exhaust vent was going to be installed. -She was "working on it as we speak."	C 074		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water temperatures were maintained between 100-116 degrees Fahrenheit (F) as evidenced by water temperatures greater than 116 degrees F for 3 of 4 fixtures used by the residents. The findings are: Observation of the residents' common hall bathroom on 05/27/21 at 11:12am revealed the water temperature in the bathtub/shower was 122 degrees F. Observation of the residents' second common hall bathroom on 05/06/21 at 11:17pm revealed:	C 105		

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C 105	Continued From page 3 -The water temperature at the sink was 121 degrees F. -The water temperature in the shower was 120 degrees F. Interview with the Supervisor-in-Charge (SIC) on 05/27/21 at 11:12am and 12:08pm revealed: -There were no water temperature logs maintained for the facility. -She did not know the state's requirement for water temperatures. -The only times the water temperatures were checked was during state or county inspections. Interview with a resident on 05/27/21 at 11:35am revealed: -He thought the water in the bathroom was too hot. -He had never been scalded by the water in the bathroom. Interview with the plumber on 05/27/21 at 12:30pm revealed: -The hot water heater thermostat was set to 120 degrees Fahrenheit (F). -He adjusted the thermostat to 110 degrees F. -He did not know the state's requirement for water temperatures. Recheck of the residents' common hall bathroom on 05/27/21 at 12:43pm revealed: -The water temperature in the bathtub/shower was 102 degrees F. Recheck of the residents' second common hall bathroom on 05/27/21 at 12:45pm revealed: -The water temperature at the sink was 102 degrees F and 101 degrees F in the shower. Attempted interview with the Administrator at	C 105		

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C 105	Continued From page 4 5:45pm was unsuccessful.	C 105		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the documentation on the medication administration records (MARs) included the initials of the medication aide (MA) who administered the medication for 3 of 3 sampled residents. The findings are: Review of three residents' MARs for March 2021-May 2021 revealed: -The Supervisor-in-Charge (SIC) documented administering all the medications during the day. -The Administrator documented administering all the nighttime medications. Interviews with a resident on 05/27/21 at 4:40pm revealed: -There were two staff who administered his	C 341		

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C 341	Continued From page 5	C 341		

medication.
-He did not recognize the Administrator's name.
-The SIC and a named male staff administered his medication.
-The named male staff worked the night shift.
-The named male staff applied ointment to his eye.
-The named male staff administered his medications on the night of 05/26/21.

Interview with a second resident on 05/27/21 at 4:43pm revealed the named male staff administered his medications on the night of 05/26/21.

Interview with a third resident on 05/27/21 at 4:44pm revealed:
-The named male staff administered his nighttime medications on 05/26/21.
-The Administrator "sometimes" worked on the weekends.

Interview with a fourth resident on 05/27/21 at 4:45pm revealed the named male staff administered his medication on the night of 05/26/21.

Telephone interview with the named male staff on 05/27/21 at 4:52pm revealed:
-He did not administer medication to the residents residing in the facility.
-He did not apply the ordered ointment to a resident's eye.
-The Administrator was at the facility "every now and then."

Interviews with the SIC on 05/27/21 at 3:56pm and 5:25pm revealed:
-The named male staff had applied the ordered ointment to a resident's eye.

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C 341	Continued From page 6 -She "pre-pulled" and let the named male staff administer medications as recently as last week. -The Administrator also pre-pulled medication and the named male staff administered the medication. Attempted interview with the Administrator on 05/27/21 at 5:45pm was unsuccessful.	C 341		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the Administrator completed the annual state mandated infection control training. The findings are:	C 934		

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C 934	Continued From page 7 Review of the Administrator's personnel record revealed: -There was no documentation of a hire date. -There were yearly infection control training certificates available. -The most recent infection control training certificate was dated 10/25/19. Telephone interview on 05/27/21 at 2:24pm with the Registered Nurse (RN) who provided training for the facility revealed: -The Supervisor-in-Charge (SIC) contacted her on 05/27/21 to schedule infection control training for the Administrator. -The Administrator had not kept up with her annual training. Interview with the Administrator on 05/27/21 at 5:45pm revealed: -She was scheduled for her annual infection control training "next week."	C 934		
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:	C935		

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C935	Continued From page 8 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: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) who administered medications had successfully completed the required state medication aide (MA) examination. The findings are: Review of Staff C's, personal care aide (PCA), personnel record revealed: -There was no hire date documented in Staff C's personnel record.	C935		

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C935	Continued From page 9 -There was no documentation Staff C completed any medication administration training. -There was no documentation Staff C passed the required state medication aide (MA) examination. Interviews with a resident on 05/27/21 at 4:40pm revealed Staff C routinely worked the night shift and administered his medications. Interview with a second resident on 05/27/21 at 4:43pm revealed Staff C routinely administered medications at night. Interview with a third resident on 05/27/21 at 4:44pm revealed Staff C administered his nighttime medications. Interview with a fourth resident on 05/27/21 at 4:45pm revealed Staff C routinely administered his nighttime medications. Telephone interview with Staff C on 05/27/21 at 4:52pm revealed: -He worked at the facility seven nights a week. -He did not administer medication to the residents residing in the facility. -He did not know if he would ever take the MA examination. Interviews with the Supervisor-in-Charge (SIC) on 05/27/21 at 3:56pm and 5:25pm revealed: -She "pre-pulled" and let Staff C administer medications to the residents as recent as last week. -The Administrator also pre-pulled medication and Staff C administered the medication. Attempted interview with the Administrator on 05/27/21 at 5:45pm was unsuccessful.	C935		