STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LISA'S FAMILY CARE HOME # 2	141 FOX RUN FOREST CITY, NC 28043

(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 follow-up survey on 07/28/21-07/29/21.	{C 000}		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and Staff B) had a criminal background check completed upon hire. The findings are: 1. Review of Staff A's, Supervisor-In-Charge (SIC) personnel record revealed: -There was no hire date listed for Staff A. -There was no documentation a criminal background check had been completed. -There was no documentation of a signed consent for a criminal background check. Interview with the SIC on 07/28/21 at 1:52pm revealed: -She was rehired by the facility as a SIC around March 2021. -She did not remember if she signed consent for a criminal background check when she was rehired. -She did not remember if a criminal background check was completed when she was rehired.	C 147		

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C 147	Continued From page 1 Telephone interview with the facility's Manager on 07/29/21 at 2:51pm revealed Staff A worked at the facility previously and was rehired on 04/13/21. Refer to the telephone interview with the facility's Manager on 07/29/21 at 2:51pm. Refer to the interview with the Administrator on 07/28/21 at 1:28pm. 2. Review of Staff B's Supervisor-In-Charge personnel record revealed: -Staff B was rehired by the facility on 05/11/21. -There was no documentation a criminal background check was completed. -There was no documentation of a signed consent for a criminal background check. Refer to the telephone interview with the facility's Manager on 07/29/21 at 2:51pm. Refer to the interview with the Administrator on 07/28/21 at 1:28pm. _____ Telephone interview with the facility's Manager on 07/29/21 at 2:51pm revealed: -He was responsible for ensuring criminal background checks were completed when staff were hired. -He did not know a background check needed to be completed for staff who previously worked for the facility and were rehired. Interview with the Administrator on 07/28/21 at 1:28pm revealed the facilty's Manager was responsible for ensuring criminal background checks were completed before staff started working at the facility.	C 147		

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C 246	Continued From page 2	C 246		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the pimary care provider (PCP) of medication refusals for 1 of 3 sampled residents (#3) who refused two nebulizer medications and one inhaler medication for two months. The findings are: Review of Resident #3's current FL2 dated 06/22/21 revealed diagnoses included dementia, bipolar disorder, and schizotypal personality disorder. a. Review of Resident #3's current FL2 dated 06/22/21 revealed there was an order for albuterol (used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases) 0.083% 2.5mg/3ml inhale 1 vial via nebulizer twice a day. Interview with Resident #3 on 07/28/21 at 1:22pm revealed: -He had stopped taking nebulizer treatments. -He no longer had a nebulizer machine. -He thought the nebulizer machine was in his drawer, but it was not there now. -The nebulizer mouthpiece "got foggy" so he stopped using it. -He felt "ok." -He did not feel he needed the nebulizer	C 246		

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treatments.
-He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the nebulizer treatments.

Observation of Resident #3's medications on hand on 07/28/21 at 2:20pm revealed there were (60) 3ml vials of albuterol sulfate 0.083% with a dispense date of 07/19/21.

Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed:
-There was an entry for albuterol 0.083% use 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm.
-The albuterol was documented as administered twice daily from 06/01/21 to 06/30/21.

Review of Resident #3's July 2021 MAR revealed:
-There was an entry for albuterol 0.083% use 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm.
-The albuterol was documented as administered twice daily from 07/01/21 to 07/27/21.

Review of a Nurses Note dated 07/28/21 revealed:
-Resident #3 was refusing breathing treatments via nebulizer.
-"We need to see if we can get these discontinued."
-Resident #3's primary care provider (PCP) wrote an order to discontinue breathing treatments.

Review of Resident #3's PCP order dated 07/29/21 revealed discontinue nebulizer and use metered dose inhaler as needed.

Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed:

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-Resident #3 had been refusing his nebulizer treatments.
-The resident told her he did no longer needed the albuterol nebulizer treatments.
-She had never given him a nebulizer treatment.

Interview with the Administrator on 07/28/21 at 1:57pm revealed:
-He knew Resident #3 had not been taking the albuterol nebulizer treatments.
-The staff was supposed to get an order to discontinue the nebulizer treatments.

Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his nebulizer treatments for 3 to 4 months.

Interview with the SIC on 07/29/21 at 8:25am revealed:
-Resident #3 had been refusing to take his nebulizer treatments of albuterol.
-The resident did not want to take the nebulizer treatments because they made him "lightheaded."
-She had administered the resident's albuterol inhaler "one or two times" because she could hear the resident was "out of breath."
-She had documented the nebulizer treatments of albuterol as administered on the MARs even though she had not administered the medications.
-The resident had a "smokers" cough, but she had not observed nor had the resident reported experiencing wheezing and shortness of breath.

Interview with the facility's Manager on 07/29/21 at 9:09am revealed:
-Resident #3 received nebulizer treatments of albuterol until late April 2021.
-Resident #3 had a nebulizer machine, but the nebulizer machine was misplaced during a move

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from one room to another room at the end of April 2021.
-He should have checked to see if staff had found the nebulizer machine.
-He did not notify the PCP the resident's nebulizer machine had been misplaced and treatments could not be administered.
-It was policy to notify the PCP if a resident refused a medication for 3 days.
-He had not notified the PCP of Resident #3' refusals of albuterol nebulizer treatments.
-He had documented administering the albuterol to Resident #3 on the MAR even though he had not administered the medications to the resident.
-The resident had not reported any problems with wheezing, shortness of breath, or other respiratory symptoms since the resident refused the albuterol nebulizer treatments.
-It was his responsibility to notify the PCP concerning medication refusals.

Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:55pm and 07/29/21 at 11:11am was unsuccessful.

b. Review of Resident #3's current FL2 dated 06/22/21 revealed there was an order for ipratropium albuterol (used to help control the symptoms of lung diseases) 0.5mg/3mg inhale 1 vial via nebulizer twice a day.

Interview with Resident #3 on 07/28/21 at 1:22pm revealed:
-He had stopped taking nebulizer treatments.
-He no longer had a nebulizer machine.
-He thought the nebulizer machine was in his drawer, but it was not there now.
-The nebulizer mouthpiece "got foggy" so he stopped using it.
-He felt "ok."

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-He did not feel he needed the nebulizer treatments.
-He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the nebulizer treatments.

Observation of Resident #3's medications on hand on 07/28/21 at 2:20pm revealed there were two boxes of (60) 3ml vials ipratropium albuterol with a dispense dates of 06/21/21 and 07/19/21.

Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed:
-There was an entry for ipratropium albuterol inhale 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm.
-The ipratropium albuterol was documented as administered twice daily from 06/01/21 to 06/30/21.

Review of Resident #3's July 2021 MAR revealed:
-There was an entry for ipratropium albuterol inhale 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm.
-The ipratropium albuterol was documented as administered twice daily from 07/01/21 to 07/27/21.

Review of a Nurses Note dated 07/28/21 revealed:
-Resident #3 was refusing breathing treatments via nebulizer.
-"We need to see if we can get these discontinued."
-Resident #3's primary care provider (PCP) wrote an order to discontinue breathing treatments.

Review of Resident #3's PCP order dated 07/29/21 revealed discontinue nebulizer and use metered dose inhaler as needed.

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C 246	Continued From page 7 Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed: -Resident #3 had been refusing his nebulizer treatments. -The resident told her he did no longer needed the ipratropium albuterol nebulizer treatments. -She had never given him a nebulizer treatment. Interview with the Administrator on 07/28/21 at 1:57pm revealed: -He knew Resident #3 had not been taking the ipratropium albuterol nebulizer treatments. -The staff was supposed to get an order to discontinue the nebulizer treatments. Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his nebulizer treatments for 3 to 4 months. Interview with the SIC on 07/29/21 at 8:25am revealed: -Resident #3 had been refusing to take his nebulizer treatments of ipratropium albuterol. -The resident did not want to take the nebulizer treatments because they made him "lightheaded." -She had administered the resident's albuterol inhaler "one or two times" because she could hear the resident was "out of breath." -She had documented the nebulizer treatments of ipratropium albuterol as administered on the MARs even though she had not administered the medications. -The resident had a "smokers" cough, but she had not observed nor had the resident reported experiencing wheezing and shortness of breath. Interview with the facility's Manager on 07/29/21 at 9:09am revealed: -Resident #3 received nebulizer treatments of	C 246		

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ipratropium albuterol until late April 2021.
-Resident #3 had a nebulizer machine, but the nebulizer machine was misplaced during a move from one room to another room at the end of April 2021.
-He should have checked to see if staff had found the nebulizer machine.
-He did not notify the PCP the resident's nebulizer machine had been misplaced and treatments could not be administered.
-He had documented administering the ipratropium albuterol to Resident #3 on the MAR even though he had not administered the medications to the resident.
-The resident had not reported any problems with wheezing, shortness of breath, or other respiratory symptoms since the resident refused the ipratropium albuterol treatments.
-It was his responsibility to notify the PCP concerning medication refusals.

Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:55pm and 07/29/21 at 11:11am was unsuccessful.

c. Review of Resident #3's current FL2 dated 06/22/21 revealed there was an order for Flovent inhaler (used to reduce airway inflammation) 110mcg 1 puff twice a day.

Interview with Resident #3 on 07/28/21 at 1:22pm revealed:
-He had stopped taking Flovent treatments.
-He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the Flovent treatment.

Observation of Resident #3's medications on hand on 07/28/21 at 2:20pm revealed there was one unopened box with one Flovent HFA 110mcg

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inhaler with a dispense date of 05/24/21.

Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed:
-There was an entry for Flovent 110mcg 1 puff two times a day scheduled for 8:00am and 8:00pm.
-The Flovent was documented as administered twice daily from 06/01/21 to 06/30/21.

Review of Resident #3's July 2021 MAR revealed:
-There was an entry for Flovent 110mcg 1 puff two times a day scheduled for 8:00am and 8:00pm.
-The Flovent was documented as administered twice daily from 07/01/21 to 07/27/21.

Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed:
-Resident #3 had been refusing his Flovent.
-The resident told her he did no longer needed the Flovent.

Interview with the SIC on 07/29/21 at 8:25am revealed:
-The resident had been refusing his Flovent inhaler.
-She had administered the resident's albuterol inhaler "one or two times" because she could hear the resident was "out of breath."
-She had documented the Flovent as administered on the MARs even though she had not administered the medication.
-The resident had a "smokers" cough, but she had not observed nor had the resident reported experiencing wheezing and shortness of breath.

Interview with the facility's Manager on 07/29/21 at 9:09am revealed:
-In April 2021, Resident #3 told him the Flovent

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C 246	Continued From page 10 made him feel dizzy and he did not like to take the medication. -He told the resident they would speak to the primary care provider (PCP) about his concerns at his June 2021 appointment. -He became aware the resident continued to refuse the Flovent inhaler this past weekend (07/24/21). -The staff had not reported to him the resident continued to refuse the Flovent, so he had not contacted the PCP to get the order discontinued. -He had planned to contact Resident #3's PCP on 07/26/21 to get the order discontinued, but he had failed to do so because he was busy with other resident care needs. -He had documented administering the Flovent to Resident #3 on the MAR even though he had not administered the medication to the resident. -It was policy to notify the PCP if a resident refused a medication for 3 days. -He had not notified the PCP of Resident #3' refusals of the Flovent. -Resident #3 had a "smoker's cough." -The resident had not reported any problems with wheezing, shortness of breath, or other respiratory symptoms since the resident refused the Flovent. -It was his responsibility to notify the PCP concerning medication refusals. Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:55pm and 07/29/21 at 11:11am was unsuccessful.	C 246		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the	{C 330}		

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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, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed practitioner for 1 of 3 sampled residents (Resident #3) related to medications used to prevent and treat wheezing, difficulty breathing, chest tightness, and cough.

The findings are:

Review of Resident #3's current FL2 dated 06/22/21 revealed diagnoses included dementia, bipolar disorder, and schizotypal personality disorder.

a. Review of Resident #3's FL2 dated 06/22/21 revealed there was an order for albuterol (used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases) 0.083% 2.5mg/3ml inhale 1 vial via nebulizer twice a day.

Interview with Resident #3 on 07/28/21 at 1:22pm revealed:
-He had stopped taking nebulizer treatments.
-He no longer had a nebulizer machine.
-He thought the nebulizer machine was in his drawer, but it was not there now.
-The nebulizer mouthpiece "got foggy" so he stopped using it.

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{C 330}	Continued From page 12 -He felt "ok." -He did not feel he needed the nebulizer treatments. -He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the nebulizer treatments. Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed: -Resident #3 had been refusing his nebulizer treatments. -The resident told her he no longer needed the nebulizer treatments. -She had never given him a nebulizer treatment. Observation of Resident #3's medications on hand on 07/28/21 at 2:20pm revealed: -There were 60 3ml vials of albuterol sulfate 0.083% with a dispense date of 07/19/21. -There were no other boxes of albuterol. Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for albuterol 0.083% use 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm. -The albuterol was documented as administered twice daily from 06/01/21 to 06/30/21. Review of Resident #3's July 2021 MAR revealed: -There was an entry for albuterol 0.083% use 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm. -The albuterol was documented as administered twice daily from 07/01/21 to 07/27/21. Interview with the Administrator on 07/28/21 at 1:57pm revealed: -He knew Resident #3 had not been taking the albuterol nebulizer treatments.	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 2	141 FOX RUN FOREST CITY, NC 28043

(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 13 -The staff was supposed to get the order discontinued. Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his albuterol nebulizer treatment for 3 to 4 months. Interview with the SIC on 07/29/21 at 8:25am revealed: -Resident #3 had been refusing to take his albuterol nebulizer treatments. -The resident did not want to take the nebulizer treatments because they made him "lightheaded." -She had documented the albuterol as administered on the MARs even though she had not administered the medication. -The resident had a "smokers" cough, but she had not observed nor had the resident reported experiencing wheezing and shortness of breath. Interview with the facility's Manager on 07/29/21 at 9:09am revealed: -Resident #3 received nebulizer treatments until late April 2021. -Resident #3 had a nebulizer machine, but the nebulizer machine was misplaced during a move from one room to another room at the end of April 2021. -The albuterol was not administered beginning in late April 2021, because the resident began refused the nebulizer treatement. -The resident told him the nebulizer medications made him feel "dizzy." -He had documented administering the albuterol to Resident #3 on the MAR even though he had not administered the medication to the resident. Review of Resident #3's Nurses Note dated 07/28/21 revealed: -The resident was refusing breathing treatments	{C 330}		

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{C 330}	Continued From page 14	{C 330}		

via nebulizer.
-"We need to see if we can get these discontinued."
-Resident #3's primary care provider (PCP) wrote an order to discontinue breathing treatments.

Review of Resident #3's PCP order dated 07/29/21 revealed discontinue nebulizer and use metered dose inhaler as needed.

Telephone interview with the facility's contracted pharmacy on 07/28/21 at 3:08pm revealed:
-The last prescription for albuterol 0.083% 1 3ml vial in nebulizer two times a day was dated 03/27/21.
-They dispensed 60 vials of albuterol on 05/24/21, 06/21/21, and 07/19/21.
-A box of 60 vials was a 30-day supply.

Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:55pm and 07/29/21 at 11:11am was unsuccessful.

b. Review of Resident #3's FL2 dated 01/06/21 revealed an order for ipratropium albuterol (used to help control the symptoms of lung diseases) 0.5mg/3mg inhale 1 vial via nebulizer twice a day.

Review of Resident #3's FL2 dated 06/22/21 revealed there was an order for ipratropium albuterol 0.5mg/3mg inhale 1 vial via nebulizer twice a day.

Observation of Resident #3's medications on hand on 07/28/21 at 2:20pm revealed there were two boxes of 60 3ml vials ipratropium albuterol with a dispense dates of 06/21/21 and 07/19/21.

Interview with Resident #3 on 07/28/21 at 1:22pm revealed:

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{C 330}	Continued From page 15	{C 330}		

-He had stopped taking nebulizer treatments.
-He no longer had a nebulizer machine.
-He thought the nebulizer machine was in his drawer, but it was not there now.
-The nebulizer mouthpiece "got foggy" so he stopped using it.
-He felt "ok."
-He did not feel he needed the nebulizer treatments.
-He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the nebulizer treatments.

Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed:
-Resident #3 had been refusing his nebulizer treatments.
-The resident told her he no longer needed the nebulizer treatments.
-She had never given him a nebulizer treatment.

Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed:
-There was an entry for ipratropium albuterol inhale 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm.
-The ipratropium albuterol was documented as administered twice daily from 06/01/21 to 06/30/21.

Review of Resident #3's July 2021 MAR revealed:
-There was an entry for ipratropium albuterol inhale 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm.
-The ipratropium albuterol was documented as administered twice daily from 07/01/21 to 07/27/21.

Interview with the Administrator on 07/28/21 at 1:57pm revealed:

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{C 330}	Continued From page 16 -He knew Resident #3 had not been taking the ipratropium albuterol nebulizer treatments. -The staff was supposed to get the order discontinued. Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his albuterol ipratropium nebulizer treatment for 3 to 4 months. Interview with the SIC on 07/29/21 at 8:25am revealed: -Resident #3 had been refusing to take his nebulizer treatments. -The resident did not want to take the nebulizer treatments because they made him "lightheaded." -She had documented the ipratropium albuterol as administered on the MARs even though she had not administered the medication. -The resident had a "smokers" cough, but she had not observed nor had the resident reported experiencing wheezing and shortness of breath. Interview with the facility's Manager on 07/29/21 at 9:09am revealed: -Resident #3 received nebulizer treatments until late April 2021. -Resident #3 had a nebulizer machine, but the nebulizer machine was misplaced during a move from one room to another at the end of April 2021. -The ipratropium albuterol was not administered beginning in late April 2021, because the resident refused it. -The resident told him the nebulizer medications made him feel "dizzy." -He had documented administering the ipratropium albuterol to Resident #3 on the MAR even though he had not administered the medication to the resident.	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 330}	Continued From page 17 Review of a Nurses Note dated 07/28/21 revealed: -The resident was refusing breathing treatments via nebulizer. -"We need to see if we can get these discontinued." -Resident #3's primary care provider (PCP) wrote an order to discontinue breathing treatments. Review of Resident #3's PCP order dated 07/29/21 revealed discontinue nebulizer and use metered dose inhaler as needed. Telephone interview with the facility's contracted pharmacy on 07/28/21 at 3:08pm revealed: -The last prescription for ipratropium albuterol 0.5mg/3mg inhale 1 vial twice a day was dated 04/24/21. -They dispensed 60 vials of ipratropium albuterol on 05/24/21, 06/21/21, and 07/19/21. -A box of 60 vials was a 30-day supply. Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:55pm and 07/29/21 at 11:11am was unsuccessful. c. Review of Resident #3's FL2 dated 06/22/21 revealed there was an order for Flovent HFA (used to reduce airway inflammation) 110mcg 1 puff po twice a day. Interview with Resident #3 on 07/28/21 at 1:22pm revealed: -He had stopped taking Flovent treatments. -He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the Flovent treatment. Observation of Resident #3's medications on	{C 330}		

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{C 330}	Continued From page 18	{C 330}		

hand on 07/28/21 at 1:10pm revealed:
-There was one unopened box with one Flovent HFA 110mcg inhaler.
-The label directions were inhale 1 puff two times a day with a dispense date of 05/24/21.

Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed:
-She did not administer Resident #3's Flovent HFA as it was ordered.
-Resident #3 told her he did not need the Flovent.

Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed:
-There was an entry for Flovent HFA 110mcg inhale 1 puff two times a day scheduled for 8:00am and 8:00pm.
-The Flovent was documented as administered twice daily from 06/01/21 to 06/30/21.

Review of Resident #3's July 2021 MAR revealed:
-There was an entry for Flovent HFA 110mcg inhale 1 puff two times a day scheduled for 8:00am and 8:00pm.
-The Flovent was documented as administered twice daily from 07/01/21 to 07/27/21.

Telephone interview with the facility's contracted pharmacy on 07/28/21 at 3:08pm revealed:
-The last prescription for Flovent 110mcg inhale 1 puff two times a day was dated 04/27/20.
-One inhaler was a 60-day supply with 120 sprays in each inhaler.
-A Flovent inhaler was dispensed to Resident #3 on 05/24/21 and 07/19/21.

Interview with the Administrator on 07/28/21 at 1:57pm revealed:
-He knew Resident #3 had not been taking the Flovent inhaler as ordered.

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{C 330}	Continued From page 19 -The staff were supposed to get an order to discontinue the Flovent. Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his Flovent for 3 to 4 months. Interview with the SIC on 07/29/21 at 8:25am revealed: -She had documented the Flovent as administered on the MARs even though she had not administered the medication. -The resident had a "smokers" cough, but she had not observed nor had the resident reported experiencing wheezing and shortness of breath. Interview with the facility's Manager on 07/29/21 at 9:09am revealed: -In April 2021, Resident #3 told him the Flovent made him feel dizzy and he did not like to take the medication. -He told the resident they would speak to the PCP about his concerns at his June 2021 appointment. -He became aware the resident continued to refuse the Flovent inhaler this past weekend (07/24/21). -The staff had not reported to him the resident continued to refuse the Flovent, so he had not contacted the PCP to get the order discontinued. -He had planned to contact Resident #3's PCP on 07/26/21 to get the order discontinued, but he had failed to do so because he was busy with other resident care needs. Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:55pm and 07/29/21 at 11:11am was unsuccessful.	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 20	C 342		
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; (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, interviews and record reviews the facility failed to ensure the medication administration record (MAR) was accurate for 2 of 3 sampled residents (Residents #2 and #3) related to accurate documentation of administration of medications to treat schizophrenia (#2) and documentation of administration of inhalation medication to prevent and treat wheezing, difficulty breathing, chest tightness, and cough (#3). The findings are:	C 342		

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C 342	Continued From page 21 1. Review of Resident #3's current FL2 dated 06/22/21 revealed diagnoses included dementia, bipolar disorder, and schizotypal personality disorder. a. Review of Resident #3's FL2 dated 01/06/21 revealed an order for albuterol (used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases) 0.083% 2.5mg/3ml inhale 1 vial via nebulizer twice a day. Review of Resident #3's FL2 dated 06/22/21 revealed there was an order for albuterol 0.083% 2.5mg/3ml inhale 1 vial via nebulizer twice a day. Interview with Resident #3 on 07/28/21 at 1:22pm revealed: -He had stopped taking nebulizer treatments. -He felt "ok." -He did not feel he needed the nebulizer treatments. -He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the nebulizer treatments. Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed: -Resident #3 had been refusing his nebulizer treatments. -She had never given him a nebulizer treatment. Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for albuterol 0.083% use 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm. -The albuterol was documented as administered twice daily from 06/01/21 to 06/30/21.	C 342		

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C 342	Continued From page 22 -There were no documented refusals of the albuterol. Review of Resident #3's July 2021 MAR revealed: -There was an entry for albuterol 0.083% use 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm. -The albuterol was documented as administered twice daily from 07/01/21 to 07/27/21. -There were no documented refusals of the albuterol. Observation of Resident #3's medications on hand on 07/28/21 at 2:20pm revealed: -There were 60 3ml vials of albuterol sulfate 0.083% available. -The label amount dispensed was 180ml (60 vials/3ml per vial) on 07/19/21. -There were no other boxes of albuterol. Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his albuterol nebulizer treatment for 3 to 4 months. Interview with the SIC on 07/29/21 at 8:25am revealed: -Resident #3 had refused to take his albuterol nebulizer treatments. -The resident did not want to take the nebulizer treatments because they made him "lightheaded." -She had documented the albuterol as administered on the MARs even though she had not administered the medication. Interview with the facility's Manager on 07/29/21 at 9:09am revealed: -Resident #3 had a nebulizer machine, but the nebulizer machine was misplaced during a move from one room to another room at the end of April 2021.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 23 -The albuterol was not administered beginning in late April 2021, because the resident refused it. -The resident told him the nebulizer medications made him feel "dizzy." -He had documented administering the albuterol to Resident #3 on the MAR even though he had not administered the medication to the resident. -His expectation was staff would document the MARs with an "R" on the front when a medication was refused and document the reason on the back of the MAR. b. Review of Resident #3's FL2 dated 01/06/21 revealed an order for ipratropium albuterol (used to help control the symptoms of lung diseases) 0.5mg/3mg inhale 1 vial via nebulizer twice a day. Review of Resident #3's FL2 dated 06/22/21 revealed there was an order for ipratropium albuterol 0.5mg/3mg inhale 1 vial via nebulizer twice a day. Interview with Resident #3 on 07/28/21 at 1:22pm revealed: -He had stopped taking nebulizer treatments. -He felt "ok." -He did not feel he needed the nebulizer treatments. -He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the nebulizer treatments. Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed: -Resident #3 had been refusing his nebulizer treatments. -She had never given him a nebulizer treatment. Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed:	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 24 -There was an entry for ipratropium albuterol inhale 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm. -The ipratropium albuterol was documented as administered twice daily from 06/01/21 to 06/30/21. -There were no documented refusals of the ipratropium albuterol. Review of Resident #3's July 2021 MAR revealed: -There was an entry for ipratropium albuterol inhale 1 vial in nebulizer two times a day scheduled for 8:00am and 8:00pm. -The ipratropium albuterol was documented as administered twice daily from 07/01/21 to 07/27/21. -There were no documented refusals of the ipratropium albuterol. Observation of Resident #3's medications on hand on 07/28/21 at 2:20pm revealed: -There were two boxes of 60 3ml vials ipratropium albuterol with a dispense dates of 06/21/21 and 07/19/21. --The label amount dispensed was 180ml (60 vials/3ml per vial) on 06/21/21 and on 07/19/21. Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his albuterol ipratropium nebulizer treatment for 3 to 4 months. Interview with the SIC on 07/29/21 at 8:25am revealed: -Resident #3 had been refusing to take his nebulizer treatments. -The resident did not want to take the nebulizer treatments because they made him "lightheaded." -She had documented the ipratropium albuterol as administered on the MARs even though she	C 342		

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LISA'S FAMILY CARE HOME # 2	141 FOX RUN FOREST CITY, NC 28043

(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
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had not administered the medication.

Interview with the facility's Manager on 07/29/21 at 9:09am revealed:
-Resident #3 received nebulizer treatments until late April 2021.
-Resident #3 had a nebulizer machine, but the nebulizer machine was misplaced during a move from one room to another room at the end of April 2021.
-The ipratropium albuterol was not administered beginning in late April 2021, because the resident refused it.
-The resident told him the nebulizer medications made him feel "dizzy."
-He had documented administering the ipratropium albuterol to Resident #3 on the MAR even though he had not administered the medication to the resident.
-His expectation was staff would document the MARs with an "R" on the front when a medication was refused and document the reason on the back of the MAR.

c. Review of Resident #3's FL2 dated 06/22/21 revealed there was an order for Flovent HFA (used to reduce airway inflammation) 110mcg 1 puff po twice a day.

Interview with Resident #3 on 07/28/21 at 1:22pm revealed:
-He had stopped taking Flovent treatments.
-He denied having experienced wheezing, shortness of breath, or tightness in his chest since having stopped the Flovent treatment.

Observation of Resident #3's medications on hand on 07/28/21 at 1:10pm revealed:
-There was one unopened box with one Flovent HFA 110mcg inhaler inside the box.

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C 342	Continued From page 26 -The label directions were inhale 1 puff two times a day with a dispense date of 05/24/21. Interview with the Supervisor-In-Charge (SIC) on 07/28/21 at 1:35pm revealed: -She did not administer Resident #3's Flovent HFA as it was ordered. -Resident #3 told her he did not need the Flovent. Review of Resident #3's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for Flovent HFA 110mcg inhale 1 puff two times a day scheduled for 8:00am and 8:00pm. -The Flovent was documented as administered twice daily from 06/01/21 to 06/30/21. -There were no documented refusals of the Flovent. Review of Resident #3's July 2021 MAR revealed: -There was an entry for Flovent HFA 110mcg inhale 1 puff two times a day scheduled for 8:00am and 8:00pm. -The Flovent was documented as administered twice daily from 07/01/21 to 07/27/21. -There were no documented refusals of the Flovent. Telephone interview with the facility's contracted pharmacy on 07/28/21 at 3:08pm revealed: -The last prescription for Flovent 110mcg inhale 1 puff two times a day was dated 04/27/20. -One inhaler was a 60-day supply with 120 sprays in each inhaler. -A Flovent inhaler was dispensed to Resident #3 on 05/24/21 and 07/19/21. Interview with the Administrator on 07/28/21 at 2:55pm revealed Resident #3 had refused his Flovent for 3 to 4 months.	C 342		

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C 342	Continued From page 27 Interview with the SIC on 07/29/21 at 8:25am revealed she had documented the Flovent as administered on the MARs even though she had not administered the medication. Interview with the facility's Manager on 07/29/21 at 9:09am revealed: -In April 2021, Resident #3 told him the Flovent made him feel dizzy and he did not like to take the medication. -He became aware the resident continued to refuse the Flovent inhaler this past weekend (07/24/21). -The staff had not reported to him the resident continued to refuse the Flovent, so he had not contacted the primary care provider (PCP) to get the order discontinued. -He had planned to contact Resident #3's primary care provider (PCP) on 07/26/21 to get the order discontinued, but he had failed to do so because he was busy with other resident care needs. -He had documented administering the Flovent to Resident #3 on the MAR even though he had not administered the medication to the resident. -His expectation was staff would document the MARs with an "R" on the front when a medication was refused and document the reason on the back of the MAR. 2. Review of Resident #2's current FL2 dated 03/31/21 revealed: -Diagnoses included schizophrenia and clozapine therapy. -There was an order for aripiprazole 20mg, one tablet daily. a. Review of Resident #2's primary care provider's (PCP) order dated 07/21/21 revealed: -Aripiprazole 20mg was discontinued.	C 342		

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C 342	Continued From page 28 -There was a new order for aripiprazole 10mg, one tablet daily. Review of Resident #2's July 2021 medication administration record (MAR) revealed: -There was an entry for aripiprazole 20mg one tablet daily at 8:00am. -The medication was documented as administered from 07/01/21 to 07/28/21. Observation on 07/28/21 at 11:15am of medications on hand for Resident #2 revealed the 8:00am pill pouch contained aripiprazole 10mg, one tablet. Interview with the Supervisor-In-Charge on 07/28/21 at 11:35am revealed: -The box containing Resident #2's current pill pouches were on a 28-day fill cycle. -When a resident's medications were changed, the change was typically made at the next fill cycle, unless the change needed to be made immediately. -The pharmacy contacted the PCP to get approval to wait until the start of the new cycle or directions to send immediately. -Resident #2's current pill cycle began on 07/26/21. -She did not change Resident #2's MAR to reflect the new aripiprazole dosage started on 07/26/21. -From 07/26/21 to 07/28/21 she documented she had administered aripiprazole 20mg, one tablet at 8:00am when she had administered aripiprazole 10mg, one tablet at 8:00am to Resident #2. -She should have changed Resident #2's MAR when she administered the new dosage of Resident #2's aripiprazole. -She was unsure why she did not change Resident #2's MAR.	C 342		

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Refer to the interview with the facility's Manager on 07/29/21 at 9:07am.

Refer to the interview with the Administrator on 07/28/21 at 3:40pm.

b. Review of Resident #2's current FL2 dated 03/31/21 revealed there was an order for clozapine 100mg, one and one-half tablet twice daily.

Review of Resident #2's PCP's orders dated 07/21/21 revealed:
-Resident #2's clozapine 150mg was discontinued.
-There was a new order for clozapine 300mg in the morning and 150mg at bedtime.

Review of Resident #2's July 2021 medication administration record (MAR) revealed:
-There was an entry for clozapine 100mg one and one-half tablet daily twice daily at 8:00am and 8:00pm.
-The medication was documented as administered from 07/01/21 to 07/28/21 at 8:00am.

Observation on 07/28/21 at 11:15am of medications on hand for Resident #2 revealed:
-The 8:00am pill pouch contained clozapine 100mg.
-The 8:00pm pill pouch contained clozapine 100mg, one and one-half tablets.
-There was separate pill package containing clozapine 200mg, one tablet daily at 8:00am for a total dose of clozapine 300mg at 8:00am.

Interview with the Supervisor-In-Charge on 07/28/21 at 11:35am revealed:
-The box containing Resident #2's current pill

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pouches were on a 28-day fill cycle.
-When a resident's medications were changed, the change was typically made at the next fill cycle, unless the change needed to be made immediately.
-The pharmacy contacted the PCP to get approval to wait until the start of the new cycle or directions to send immediately.
-Resident #2's current pill cycle began on 07/26/21.
-She had not changed Resident #2's MAR to reflect the new clozapine order on 07/26/21.
-From 07/26/21 to 07/28/21 she documented she had administered clozapine 150mg, twice daily which was not accurate.
-She should have changed Resident #2's MAR when she administered the new dosage of Resident #2's clozapine.
-She was unsure why she did not change Resident #2's MAR.

Refer to the interview with the facility's Manager on 07/29/21 at 9:07am.

Refer to the interview with the Administrator on 07/28/21 at 3:40pm.

_____

Interview the facility's Manager on 07/29/21 at 9:07am revealed:
-He expected the SIC to change resident MARs when necessary to accurately reflect any order changes by the provider.
-All SICs were trained to compare the medication with the MAR and to contact him or the pharmacy if there was a discrepancy.
-He expected resident MARs to be accurate.

Interview with the Administrator on 07/28/21 at 3:40pm revealed:
-All facility SICs could make changes to resident

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C 342	Continued From page 31 MARs when they received a new order. -The SIC was to contact the facility's Manager with any medication questions or concerns. -He expected resident MARs to be accurate.	C 342		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services	C 612		

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C 612	Continued From page 32 (NCDHHS) were implemented when caring for 6 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of visitors and staff not wearing required mask. The findings are: Review of the CDC guidelines dated 03/29/21 for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed: -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Healthcare Personnel should always wear a well-fitting facemask while they are in the healthcare facility. Review of the NC DHHS guidelines dated 05/05/21 for the prevention and spread of the Coronavirus Disease in LTC facilities revealed: -Recommended routine infection prevention control (IPC) practices during the COVID-19 pandemic include screening everyone entering a healthcare facility for signs and symptom of COVID-19 by temperature checks, screening questions, and observations of signs and symptoms. -Establish a process to ensure visitors entering the facility are assessed for symptoms of COVID-19 and temperature was checked. -Proper visitor education on COVID-19 signs and symptoms, infection control precautions, and use of a face covering or mask. Review of the facility's Infection Control (COVID-19) policy dated 05/20/20 revealed:	C 612		

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C 612	Continued From page 33 -The policy was designed to identify and reduce the risk of acquiring and transmitting infections among residents, visitors, and healthcare workers. -Visitors will have their temperature checked upon entrance. -Masks are provided to staff. -Employees support resident safety by adhering to all policies and procedures related to infection prevention, including standard and transmission-based precautions. a. Observation of a medication aide (MA) on 07/28/21 at 9:55am revealed she allowed two Surveyors into the facility with no COVID-19 screening or temperature checks. Observation of the facility's COVID-19 screening log on 07/28/21 at 10:00am revealed: -The screening log was located on a clipboard on the wall. -The entries on the log were dated 02/09/21 to 06/25/21. -The screening entries included a temperature check, recent exposure screening, and symptom screening. Interview with the MA on 07/29/21 at 8:25am revealed: -Visitors were supposed to have their temperatures checked and if the temperature was 100.0 degrees or greater, they were denied entry. -Visitors were supposed to be screened for recent exposure and symptom screening upon entry. -She had forgotten to screen the Surveyors upon entry. -She was responsible for screening visitors and documenting those screenings during her shift. Interview with the facility's Manager on 07/29/21	C 612		

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C 612	Continued From page 34 at 9:09am revealed: -All visitors were supposed to have their temperature checked and be screened for recent exposure and symptoms of COVID-19. -Staff were expected to document visitor temperature checks and screening information on the screening log located at the entrance to the facility. Interview with the Administrator on 07/29/21 at 2:00pm revealed the facility's Manager was responsible for ensuring staff were screening visitors and documenting it on the COVID-19 screening log. b. Observation of a medication aide (MA) on 07/28/21 at 9:55am revealed the MA was not wearing a facemask. Interview with one resident on 07/28/21 at 3:40pm revealed staff wore masks "most of the time." Interview with a second resident on 07/29/21 at 11:45am revealed staff wore masks "sometimes." Interview with the MA on 07/29/21 at 8:25am revealed: -Staff were supposed to wear a mask while they were inside the facility. -Staff could remove the mask while in the office. -She had forgotten to put her mask on after leaving the office on the morning of 07/28/21 when greeting the Surveyors at the front door. -The Administrator had reminded her to put on a mask when he arrived on 07/28/21 at 10:15am and she complied. Interview with the facility's Manager on 07/29/21 at 9:09am revealed: -It was the facility's policy for staff to wear a face	C 612		

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C 612	Continued From page 35 mask anytime they were outside the office. -Staff were expected to wear a mask anytime a resident or visitor came into the office to speak with the staff. -The staff were not expected to wear a mask when they were eating, drinking, or smoking. Interview with the Administrator on 07/29/21 at 2:00pm revealed the facility's Manager was responsible for ensuring staff were wearing masks while inside the facility.	C 612		
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.	C935		

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C935	Continued From page 36 (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 A) who administered medications had completed the medication administration competency validation clinical skills checklist prior to administering medications and the 5, 10, or 15 hour state approved medication administration training courses within 60 days of hire. The findings are: Review of Staff A's, Supervisor-In-Charge (SIC), personnel record reveled: -There was no hire date listed for Staff A. -There was documentation Staff A passed the written medication aide examination on 02/18/20. -There was documentation Staff A completed a 5-hour medication administration training course on 02/04/20. -There was no documentation Staff A had completed 10 additional hours of a state approved medication administration training	C935		

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C935	Continued From page 37	C935		

course.
-There was no documentation Staff A completed the medication administration competency validation clinical skills checklist.

Review of a resident's Medication Administration Record (MAR) for June 2021 and July 2021 revealed Staff A documented administering medications.

Interview with the SIC on 07/28/21 at 1:52pm revealed:
-She was rehired by the facility around March 2021.
-She passed medications to residents regularly since she was rehired.
-She did not complete a medication administration competency validation clinical skills checklist when she was rehired.
-She was unsure if she completed 10 additional hours of a state approved medication administration training course.

Telephone interview with the facility's Manager on 07/29/21 at 2:51pm revealed:
-Staff A was rehired on 04/13/21.
-He was responsible for ensuring SICs completed the 5, 10, or 15 hour state approved medication administration training courses prior to administering medications.
-He was responsible for ensuring the medication administration competency validation clinical skills checklist was completed prior to a SIC administering medications.
-He thought Staff A completed the training and the clinical skills checklist when she was rehired.

Interview with the Administrator on 07/28/21 at 1:28pm revealed:
-Staff A had worked for the facility previously and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081053	A. BUILDING: _____ B. WING _____	R-C 07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 2	141 FOX RUN FOREST CITY, NC 28043

(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
C935	Continued From page 38 was rehired on 04/13/21. -The Manager was responsible for ensuring SICs had all required training prior to passing medications including the 5, 10, or 15 hour state approved medications administration training courses and the clinical skills checklist.	C935		
{C992}	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or	{C992}		

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{C992}	Continued From page 39 employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff A) prior to hire. The findings are: Review of Staff A's, Supervisor-In-Charge (SIC), personnel record revealed: -There was no hire date listed for Staff A. -There was no documentation Staff A completed an examination and screening for the presence of controlled substances prior to hire. Interview with the SIC on 07/28/21 at 1:52pm revealed: -She was rehired by the facility as a SIC around March 2021. -She did not have a drug screen completed when she was rehired. -The Manager and the Administrator reminded her about once a week to get the drug screen done but she had not yet had it done. Interview with the facility's Manager on 07/29/21 at 9:07am revealed: -The SIC was rehired on 04/13/21. -He and the Administrator were responsible for ensuring drug screens were completed when staff were hired. -He tried to remind newly hired staff weekly to complete the drug screen.	{C992}		

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{C992}	Continued From page 40 Interview with the Administrator on 07/28/21 at 1:28pm revealed: -He was aware the SIC did not have a drug test completed when she was rehired. -The SIC had a drug test scheduled for 07/30/21. -The Manager was responsible to ensure all new hires had drug tests completed.	{C992}		