STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL073011	A. BUILDING: _____ B. WING _____	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS FAMILY CARE HOME	410 MONTFORD DRIVE ROXBORO, NC 27573

(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 June 30,2021.	C 000		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 3 staff (Staff A) had documentation of a completed Licensed Health Professional Support (LHPS) competency validation prior to performing the LHPS task of nebulizer treatments and Finger Stick Blood Sugar (FSBS). The findings are: Review of Staff A, personal care aide's (PCA) personnel record revealed: -There was no hire date documented. -There was no signed job description. -There was documentation Staff A completed the medication clinical skills competency validation	C 171		

Reviewed and acknowledged 08/10/21.
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C 171	Continued From page 1 on 08/02/20. -There was documentation Staff A completed the 15-hour medication administration training on 08/02/17. -There was no documentation that an LHPS competency validation had been completed. Review of two residents' Medication Administration Records (MAR) for April 2021-June 2021 did not reveal Staff A had documented performing Finger Stick Blood Sugar (FSBS) checks or administered nebulizer treatments. Interview with two residents on 06/30/21 between 8:35am-9:05am revealed: -Staff A administered medication today, 06/30/21. -Staff A administered nebulizer treatments, but they did not recall when Staff A last administered the nebulizer treatments. -Staff A checked one resident's FSBS, but he did not recall when Staff A had last performed FSBS. Interview with Staff A on 06/30/21 at 10:23am, 1:02pm and 4:32pm revealed: -He was a personal care aide (PCA). -He had been working at the facility "on and off" for several years. -He had taken time off for medical reasons but returned in June 2020. -He administered the resident's medication today, 06/30/21. -He administered medications at other times as well but did not recall the specific dates/times. -He did not sign off on the medication administration records (MAR). -He had not signed off on the MARs in over 2-years. -He did not sign off on the MARs because the MA was the one who punched the medications into	C 171		

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C 171	Continued From page 2 the individual medication cups, so the MA documented them on the MARs. -There were two residents who had nebulizer treatments. -The residents were able to open the medication vial, pour it into their nebulizer medication cup, and use the nebulizer machine on their own. -He made sure the residents completed the nebulizer treatment. -He checked a resident's FSBS yesterday, 06/29/21. -He checked a resident's FSBS at other times as well. -No one had observed him completing LHPS tasks. -The Administrator, who was a nurse, was the only person who observed him administering medications. Telephone interview with the Administrator on 06/30/21 at 5:05pm revealed: -She was responsible for maintaining personnel records. -Staff A had an LHPS competency validation completed; she did not know why it was not in his personnel records. -She audited all the personnel records "about six weeks ago" and the documentation was in the record.	C 171	hire date is in chart, Job script in chart new ck skills in chart. LHPS in chart, STAFF A had class following Friday after U left since I could not locate his at all. Admin will ck charts every 90 days to make sure document are up to date and fill in the chart. Job description was in chart dated AUG 1 2017. But I had him do a new one ☺ 9/15/21	
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or	C 249		

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C 249	Continued From page 3 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 1 sampled resident (Resident #1) with orders for finger stick blood sugar (FSBS) checks on Mondays, Wednesdays, and Fridays (MWF). The findings are: Review of Resident #1's current FL-2 dated 04/22/21 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), vascular dementia, and a history of cerebrovascular disease. -There was an order for finger stick blood sugar (FSBS) checks on Mondays, Wednesdays and Fridays (MWF). Interview with Resident #1 on 06/30/21 at 10:52am revealed: -He sometimes had his FSBS checked. -He did not remember when he last had his FSBS checked, it had been a while. Review of Resident #1's April 2021 medication administration record (MAR) revealed: -There was an entry to check Resident #1's FSBS in the morning before breakfast on MWF with a scheduled time of 7:30am. -There was documentation Resident #1's FSBS was checked every MWF with documented ranges of 99-160. Review of Resident #1's May 2021 medication administration record (MAR) revealed:	C 249		

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C 249	Continued From page 4 -There was an entry to check Resident #1's FSBS in the morning before breakfast on MWF with a scheduled time of 7:30am. -There was documentation Resident #1's FSBS was checked every MWF with documented ranges of 90-119. Review of Resident #1's June 2021 medication administration record (MAR) revealed: -There was an entry to check Resident #1's FSBS in the morning before breakfast on MWF with a scheduled time of 7:30am. -There was documentation Resident #1's FSBS was checked every Tuesday, Thursday and Saturday or Sunday with documented ranges of 97-108. Observation of Resident #1's medications on hand on 06/30/21 at 12:35pm revealed: -Resident #1 did not have any lancets. -Resident #1 had 38 glucometer test strips on hand. Observation of Resident #1's glucometer on 06/30/21 at 12:35pm revealed: -When turned on the glucometer had a date of 04/29 and a time of 9:27am displayed with a FSBS reading of 73. -When the down button was used the next reading was dated 03/29 and the time of 2:02pm was displayed with a FSBS reading of 93. -When the down button was used the next reading was dated 04/04 and the time of 6:02am was displayed with a FSBS reading of 97. -When the down button was used the next reading was dated 04/08 and the time of 6:46am was displayed with a FSBS reading of 112. -When the down button was used the next reading was dated 04/12 and the time of 2:45pm was displayed with a FSBS reading of 199.	C 249	FBS supplies will be in stock at all times. and the meter will be set. BS will be taken + document mon wed FRI 730.am. Admin will ck this. every month and give reminders to whoever working to be sure to do blood sugars.	

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C 249	Continued From page 5 -When the down button was used the next reading was dated 04/14 and the time of 10:15am was displayed with a FSBS reading of 160. -When the down button was used the next reading was dated 04/18 and the time of 3:09pm was displayed with a FSBS reading of 200. -When the down button was used the next reading was dated 04/20 and the time of 3:04pm was displayed with a FSBS reading of 178. -When the down button was used the next reading was dated 04/24 and the time of 3:26pm was displayed with a FSBS reading of 167. -When the down button was used the next reading was dated 04/28 and the time of 12:08pm was displayed with a FSBS reading of 222. -When the down button was used the next reading was dated 04/29 and the time of 6:48am was displayed with a FSBS reading of 360. -When the down button was used the next readings were dated from 04/29-04/30 at various times with readings of 547, 477, 344, 355, and 304. -When the down button was used the next readings were dated 05/01-05/23 at various times with readings of 308, 432, 303, 298, 383, 168, 400, 274, 341, 300, 275, 234, 259, 239, 204, 299, 239, 398, 250, 242, 242, 223, 368, 200, 264, 118, 166, 161, 180, 147, -When the down button was used the next readings were dated from 06/01-06/30 at various times with readings that ranged between 92-398. -When the down button was used the next readings were dated from 07/01-07/21 at various times with readings of 120-253. Second observation of Resident #1's glucometer on 06/30/21 at 2:54pm revealed: -When turned on the glucometer had a date of 04/29 and a time of 9:27am displayed with a FSBS reading of 73.	C 249		

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C 249	Continued From page 6 -When the up button was used the next reading was dated 02/22 and the time of 6:07am was displayed with a FSBS reading of 107. -When the up button was used the next reading was dated 02/08 and the time of 5:28am was displayed with a FSBS reading of 98. -When the up button was used the next reading was dated 02/01 and the time of 5:53am was displayed with a FSBS reading of 99. -When the up button was used the next reading was dated 01/31 and the time of 5:13am was displayed with a FSBS reading of 113. The next reading was the 73 dated 04/29 at 9:27am and continued the cycle observed on 06/30/21 at 12:35pm. -There were no other readings in the glucometer. Second interview with Resident #1 on 06/30/21 at 3:20pm revealed: -FSBS was when they stuck him on the end of his finger and then put it in the machine. -He did not remember when the FSBS was done last, it had been a long time. -No one checked his FSBS today 06/30/21 or yesterday, 06/29/21. -His memory was not "all that good" but he knew it had been a while. Interview with the Facility Manager/medication aide (MA) on 06/30/21 at 12:38pm revealed: -He checked Resident #1's FSBS last; he checked it this morning (06/30/21). -Resident #1's FSBS were checked three times a week. -Resident #1's glucometers date and time had not been set. -He could not explain why the readings displayed in the glucometer presented for Resident #1 did not match the readings documented in the MAR. -Resident #1 had never had a reading as high as	C 249		

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C 249	Continued From page 7 were displayed in the glucometer. -Resident #1's FSBS were always low, in the upper 90's-low to mid-one hundred. Interview with the personal care aide (PCA) on 06/30/21 at 1:00pm revealed: -He checked Resident #1's FSBS yesterday, 06/29/21. -He had not documented the reading on Resident #1's MAR but wrote the results down on a piece of paper. -The piece of paper presented had a FSBS of 99 written beside the resident's name. -He did not know why the reading of 99 was not displayed in Resident #1's glucometer, maybe he wrote it down incorrectly. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 06/30/21 at 1:41pm revealed Resident #1's glucometer supplies had not been dispensed from their pharmacy. Second interview with the Facility Manager/medication aide (MA) on 06/30/21 at 2:40pm revealed: -He thought Resident #1 was alert and oriented and could answer questions appropriately. -Resident #1's glucometer strips were obtained through a local pharmacy. -Resident #1 was out of lancets. Telephone interview with a pharmacy technician at the local pharmacy on 06/30/21 at 4:02pm revealed they had not dispensed lancets or glucometer strips for Resident #1. Second interview with the PCA on 06/30/21 at 4:50pm revealed: -He had to call Resident #1's insurance agency to	C 249		

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C 249	Continued From page 8 get prior authorization to obtain the lancets and strips. -The insurance representative would then call the local pharmacy to authorize the prescription to be filled for the lancets and strips. -He did not recall when he last ordered the lancets and strips. -He used the last lancet last week. -He checked Resident #1's FSBS since then by wiping the lancet off that was in the machine with alcohol. Telephone interview with Resident #1's insurance agency on 06/30/21 at 5:46pm revealed: -Their agency did have to approve the purchase of lancets and strips for Resident #1's glucometer. -There were no requests in 2021 to refill the glucometer supplies. -She was not able to review Resident #1's authorization history prior to 2021. Telephone interview with the Administrator on 06/30/21 at 5:05pm revealed: -When she worked last week on 06/23/21 she took Resident #1's FSBS. -Resident #1 had 10-15 lancets available on 06/23/21. -She did not know why there were readings in Resident #1's glucometer that did not match his MARs. -Resident #1's FSBS were always low. Telephone interview with Resident #1's primary care provider (PCP) on 07/01/21 at 4:02pm revealed: -The FSBS readings documented were reviewed during office visits, and he thought the "numbers looked pretty good." -Resident #1 had hypoglycemia (low blood	C 249		

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C 249	Continued From page 9 sugar). -He looked at Resident #1's MARs and believed the numbers documented represented Resident #1's FSBS. -It was concerning if Resident #1's FSBS documented on the MAR were not accurate. -Resident #1's most recent AIC's accurately reflected the FSBS documented. (The American Diabetes Association recommends a hemoglobin A1C target level of less than 6.5%. The AIC gives you a picture of the average FSBS control for the past 2 to 3 months.) Based on interviews, record reviews, and observations it could not be determined if Resident #1's order for FSBS three times per week had been implemented.	C 249		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container;	C 335		

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C 335	Continued From page 10 (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination and spillage for 2 of 3 residents (#2 and #3). The findings are: Observation of the medication storage room on 06/30/21 at 9:11am revealed: -There were two medications cups sitting on top of a file cabinet. -There were six resident names written on tape, applied to the top of the file cabinet. -The two medication cups were not labeled with resident names or the medications in the cups. -The medication cups did not have a lid. -The two medication cups were placed by	C 335		

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C 335	Continued From page 11 Resident #2 and Resident #3's name. -The cup placed by Resident #2's name contained 2 round white tablets and one yellow capsule. -The cup placed by Resident #3's name contained one oblong pink tablet. -The medication storage room was not locked between 9:11am-4:18pm. Interview with the Facility Manager/Medication Aide (MA) on 06/30/21 at 10:18am revealed: -He punched all the resident's medications into plastic medication souffle cups early today, 06/30/21. -He placed the medication cups on top of the file cabinet to be administered later because the residents were asleep. -He instructed Staff A to administer the medications when the residents got up for breakfast. -He did not know the medication cups needed to be labeled with the resident's names and the medications that had been punched. -He did not know any medication that was pre-poured had to be labeled with the resident's name, medications and covered to prevent the medication from being spilled or contaminated. Telephone interview with the Administrator on 06/30/21 at 5:05pm revealed: -The Facility Manager/MA pre-poured medications to be administered, but never more than 24-hours in advance. -They had "always done it this way." -She did not know any medication that was pre-poured had to be labeled with the resident's name, medications and covered to prevent the medication from being spilled or contaminated. -It did sound safer to label and cover the cups.	C 335	meds will be closed label + Co Accts. Admin will check monthly + periodic. And locked in med Closet.	July 5/21

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C 341	Continued From page 12	C 341	meds will have to post any med pre made up will be labeled with name + Contents and locked in med Room. Unless there is a definite Reason to do this meds will not be prepared anymore listing the contents is way too much. Admin will check on this and make sure everyone knows Rules on this. (ck Monthly)	July 15/21
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 (#1, #2, and #3). The findings are: Interviews with three residents on 06/30/21 between 8:35am-9:05am revealed: -A named staff had administered medication today, 06/30/21. -The named staff had administered medications on other days as well but could not recall specific dates/times. -"Whoever was working administered medications." Review of three residents Medication Administration Records (MARs) for April	C 341		

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(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 341	Continued From page 13 2021-June 2021 revealed: -The named staff members initials were not documented as administering medications. -The Facility Manager/Medication Aide (MA) had documented administering medications. -The Administrator had documented administering medications. Interview with the named staff on 06/30/21 at 10:23am revealed: -He was a personal care aide (PCA) and had been working at the facility off and on for years. -He administered the resident's medication today, 06/30/21. -He administered medications at other times as well but did not recall the specific dates/times. -He did not sign off on the medication administration records (MAR). -He had not signed off on the MARs in over 2-years. -He did not sign off on the MARs because the MA was the one who punched the medications into the individual medication cups, so the MA documented on the MARs. Interview with the Facility Manager/MA on 06/30/21 at 4:32pm revealed: -The PCA administered medications today, 06/30/21. -Usually, he or the Administrator initialed the MARs. -The PCA did not initial the MARs because he punched the medications into the medication cups, so he was the one who documented on the MARs. -He used the MARs to punch the medication and documented on the MAR as he punched the medication. Telephone interview with the Administrator on	C 341		

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	FCL073011	A. BUILDING: _____ B. WING _____	06/30/2021

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C 341	Continued From page 14 06/30/21 at 5:05pm revealed: -Whoever administered the resident's medications should document on the MARs. -If the PCA administered medication, she expected the PCA to document on the MAR.	C 341	If you give out meds u must document July 5/21 Admin will make sure this is done more	
C 350	10A NCAC 13G .1005 (a) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) When there is a change in the resident's mental or physical ability to self-administer or resident non-compliance with the physician's orders or the facility's medication policies and procedures, the facility shall notify the physician. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 residents sampled (#1, #2, and #3) who	C 350		

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C 350	Continued From page 15 self-administered medications had orders to self-administer prescription medications that were kept in the residents' rooms including a nebulizer treatment and an inhaler (#1 and #2); and eye drops (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 04/22/21 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), vascular dementia, and a history of cerebrovascular disease. -There was no order to self-administer medications. Review of Resident #1's physician's order dated 05/21/21 revealed: There was an order for Ipratropium Albuterol (a bronchodilator) inhale one vial in the am and in the pm and prn (as needed) for shortness of breath or wheezing. -There was no order to self-administer the Ipratropium nebulizer treatments. Observation of Resident #1's room on 06/30/21 at 8:52am revealed: -Resident #1 had a nebulizer machine on his bedside table (a nebulizer is a machine that turns liquid medication into a fine mist to treat asthma often called a breathing treatment). -There were three boxes with prescription labels for the Ipratropium Albuterol. -Two of the three boxes were empty; one box had five unused vials of medication. Interview with Resident #1 on 06/30/21 at 8:51am revealed: -He used his nebulizer machine every day. -He always kept his nebulizer medication "right	C 350	orders are now In chart for eyedrops and nebulizer. not sure how orders got lost. they were there. doc Send new ones they are in chart. Admin will make sure quarterly by Cheryn charts	

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C 350	Continued From page 16 here" indicating his nightstand. -He did not know if there was an order for him to self-administer his nebulizer medication, but he always did it himself. Interview with the personal care aide (PCA) on 06/30/21 at 10:23am revealed: -Resident #1 used his nebulizer twice a day, in the am and the pm. -Resident #1 could open the medication vial and use it by himself. -He made sure Resident #1 completed his nebulizer treatments. -He did not know if Resident #1 had an order to self-administer his nebulizer treatments. Interview with the Facility Manager/MA on 06/30/21 at 3:04pm revealed: -Resident #1 should not have the Ipratropium Albuterol in his room and the medication should be administered by staff. -Resident #1 should not be self-administering the Ipratropium Albuterol nebulizer treatments. -He did not think Resident #1 was administering the medication but would hold the nebulizer after the PCA had administered the vial of medication into the nebulizer machine. Telephone interview with the Administrator on 06/30/21 at 5:05pm revealed: -She was not aware Resident #1's Ipratropium Albuterol was in the resident's room. -She did not know who had left the medication on Resident #1's bedside table. -She was concerned the PCA had not listened to her when she was training him on medication administration. -She worked in the facility one-day last week when the PCA had an appointment. -She had not observed the medication on	C 350	nebulizers will be meds Kept locked in Staff med room Admin will ck to make sure they stay in there, not in rooms once a week. A self Admin for this is being seeked for doctor. Discussions will be made abt this. July 15 21	

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C 350	Continued From page 17 Resident #1's bedside table. Telephone interview with Resident #1's primary care provider (PCP) on 07/01/21 at 4:02pm revealed: -Resident #1 knew when he needed a nebulizer treatment. -He did not recall writing an order for Resident #1 to self-administer his nebulizer treatments, but there was no "downside" to the resident doing so. 2. Review of Resident #2's current FL-2 dated 02/25/21 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD) and emphysema. There was an order for Ipratropium Albuterol (bronchodilator) inhale one vial prn (as needed) for shortness of breath or wheezing. -There was no order to self-administer the Ipratropium nebulizer treatments. Observation of Resident #2's room on 06/30/21 at 8:58am revealed: -Resident #2 had a nebulizer machine on his bedside table (a nebulizer is a machine that turns liquid medication into a fine mist to treat asthma often called a breathing treatment). -There were four vials of a liquid medication; there was no prescription box or label to identify the medication. Interview with Resident #2 on 06/30/21 at 8:58am and 11:30am revealed: -He used his nebulizer machine every day, "it helped me breathe better." -No staff assisted him with his nebulizer treatments, he could do it himself. -The PCA had helped him with the nebulizer treatments "a long time ago."	C 350		

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C 350	Continued From page 18 Interview with the personal care aide (PCA) on 06/30/21 at 1:02pm revealed: -Resident #2 was wheezing "about every day" so he would encourage him to use his nebulizer twice a day. -Resident #2 could open the medication vial and use it by himself. -He made sure Resident #2 completed his nebulizer treatments. -He did not know if Resident #2 had an order to self-administer his nebulizer treatments. Interview with the Facility Manager/MA on 06/30/21 at 3:04pm revealed: -Resident #2 did not self-administer his own nebulizer treatments. -The PCA probably broke a vial of the medication off, laid the others down while adding the vial to the nebulizer treatment cup and forgot to pick the additional vials back up. Telephone interview with the Administrator on 06/30/21 at 5:05pm revealed: -Resident #2 did not have an order to self-administer his nebulizer medication. -She was not aware Resident #2's Ipratropium Albuterol was in the resident's room. -She did not know who had left the medication on Resident #2's bedside table. -She was concerned the PCA had not listened to her when she was training him on medication administration. -She worked in the facility one-day last week when the PCA had an appointment. -She had not observed the medication on Resident #2's bedside table. Attempted telephone interview with Resident #2's primary care provider (PCP) on 06/30/21 at 4:12pm was unsuccessful.	C 350		

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C 350	Continued From page 19 3. Review of Resident #3's current FL-2 dated 02/25/21 revealed: -Diagnoses included morbid obesity, schizophrenia, bipolar, hyperlipidemia and vitamin D deficiency. -There was an order for Timolol Maleate eye drops (used to reduce pressure in the eyes), place one drop in each eye every morning. -There was no order to self-administer the Timolol Maleate eye drops. Observation of Resident #3's room on 06/30/21 at 9:05am revealed: -There was a bottle of eye drops sitting on the resident's bedside table. -The eye drops were labeled for Resident #3 and to place one drop in each eye every morning. Interview with Resident #3 on 06/30/21 at 9:05am revealed: -He administers his own eye drops when he first gets up in the morning. -The medication was not usually kept in his room. -The staff would take him the eye drops; he would administer them himself and give the medication bottle back to the staff. -He "forgot" to give the eye drop bottle back to the staff today, 06/30/21. Interview with the Facility Manager/Medication Aide (MA) on 06/30/21 at 10:45am revealed: -Resident #3 gave himself his eye drops. -There was an order for Resident #3 to self-administer his eye drops. -He did not know why the self-administer order was not in Resident #3's record, "he has had that order for a long time." Telephone interview with the Administrator on	C 350		

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C 350	Continued From page 20 06/30/21 at 5:05pm revealed: -She was aware Resident #3 had eye drops in his room. -Resident #3 had an order to self-administer his eye drops. -Resident #3's eye drops should be kept in the drawer of the bedside table, not on top. -Staff knew the eye drops should be placed inside the resident's drawer. There was no order presented for self-administration of Resident #3's eye drops dated prior to 06/30/21 before the end of the survey. Attempted telephone interview with Resident #3's primary care provider (PCP) on 06/30/21 at 4:12pm was unsuccessful.	C 350	any meds self Admin will be kept out of site and away from other clients. July 15th	
C 353	10A NCAC 13G .1006(b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure medications were maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration for six residents that resided in the facility.	C 353	med storage door will be locked all times. Admin will check this once weekly. and Reminders to keep door locked no matter what July 15th	

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C 353	Continued From page 21 The findings are: Observation of the medication storage room on 06/30/21 between 9:11am-4:18pm revealed: -There was a door with a sign, staff only. -The door had a padlock that was not locked. -The room contained a file cabinet that was not locked, a box of punch cards with resident's medications, and canned food. -There were two medications cups sitting on top of a file cabinet that contained medication. -The medication storage room was not locked between 9:11am-4:18pm. -At 11:44am the Facility Manager/medication aide (MA) left the door open to the medication storage room. -At 11:46am the Facility Manager/MA shut the door but did not lock the padlock. -At 11:51am the medication storage room door was open and there was no staff in the immediate area; the door was open and the room unattended for five minutes. -At 12:10pm the medication storage room door was open and there was no staff in the immediate area; the door was open and the room unattended for twelve minutes. -The medication storage room could not be seen directly from the kitchen area. Interview with the personal care aide (PCA) on 06/30/21 at 4:19pm revealed: -The file cabinet did not lock, but the medication storage door locked. -He had not locked the medication storage door because the Facility Manager/MA had been at the facility all day. -If he went outside to mow the grass, he would lock the medication storage room door. -He did not lock the medication storage room	C 353		

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C 353	Continued From page 22 because he was going in and out of the closet to get food for lunch. -The residents were not going to go into the medication storage room unless they were going to get a snack. -The only time he could recall a resident was in the storage room was when he was administering medication, had to step away for "just a minute" and when he came back the resident was getting food; it was a long time ago. Interview with the Facility Manager/MA on 06/30/21 at 4:32pm revealed: -The medication storage room was not locked because the PCA was preparing lunch and was going in and out of the storage room. -There was a camera that faced the medication storage room. -He expected the medication storage room to be locked when the room was unattended. Telephone interview with the Administrator on 06/30/21 at 5:05pm revealed: -The medication storage closet should be locked if the staff was not administering medications or getting food from the pantry. -The closet was probably left unlocked because the staff was preparing lunch and getting food. -She was not concerned that the residents would go into the medication storage closet, "my residents are not like that." -She was concerned because it was a rule, and something could possibly happen.	C 353		
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	C935		

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C935	Continued From page 23 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 procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by:	C935	Staff n will do Test 60 days from skills ck list. Or he cant do medication at all. Had class 2day after left. Skills ck + LHPS validation 7/15/21	

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C935	Continued From page 24 Based on interviews, and record reviews, the facility failed to assure 1 of 3 sampled medication aides (Staff A) who administered medications had successfully completed the required state medication aide (MA) examination. The findings are: Review of Staff A, personal care aide's (PCA) personnel record revealed: -There was no hire date documented. -There was no signed job description. -There was documentation Staff A completed the medication clinical skills competency validation on 08/02/20. -There was documentation Staff A completed the 15-hour medication administration training on 08/02/17. -There was no documentation Staff A passed the required state medication aide (MA) examination. Interview with the Facility Manager/Medication Aide (MA) on 06/30/21 at 10:18am revealed: -He had punched all the resident's medications into plastic medication souffle cups early today, 06/30/21. -He had placed the medication cups on top of the file cabinet to be administered later, because the residents were asleep. -He had instructed Staff A to administer the medications when the residents got up for breakfast. Interview with Staff A on 06/30/21 at 10:23am revealed: -He had been working at the facility "on and off" for several years. -He had taken time off for medical reasons but returned in June 2020. -He administered the resident's medication today,	C935	hire date Job Script UHPs newest list in chart. Admin will ck quarterly for that exact paperwork.	July 15-21

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C935	Continued From page 25 06/30/21. -He administered medications at other times as well but did not recall the specific dates/times. -He did not sign off on the medication administration records (MAR). -He had not signed off on the MARs in over 2-years. -He did not sign off on the MARs because the MA was the one who punched the medications into the individual medication cups, so the MA documented on the MARs. Interviews with three residents on 06/30/21 between 8:35am-9:05am revealed: -Staff A administered medication today, 06/30/21. -Staff A administered medications on other days as well but could not recall specific dates/times. -"Whoever was working administered medications." Telephone interview with the Administrator on 06/30/21 at 5:05pm revealed: -She was training Staff A to administer medications. -Staff A did not usually administer medication independently but did so today, 06/30/21, because the MA was not able to be at the facility during the scheduled medication administration time. -Staff A had taken multiple leaves of absence from the facility due to medical reasons and returned "about six weeks ago." -She thought Staff A had 90-days to take the state MA examination and he just returned about six weeks ago. -She did not have a new medication clinical skills validation checklist completed when Staff A returned six-weeks ago.	C935		