Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION
	FCL074080	A. BUILDING _____ B. WING _____

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND C FAMILY CARE HOME, LLC	6347 FAIRWAY DRIVE GRIFTON, NC 28530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey, follow-up survey, and complaint investigation on August 2, 2022	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021 This Rule is not met as evidenced by Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff members (Staff A) received a test for tuberculosis upon hire The findings are Review of Staff A's medication aide (MA) personnel record revealed: Staff A was hired on 01/22/21 as a MA. There was documentation that Staff A received a tuberculosis (TB) skin test on 05/19/21 from the [illegible] department (LHD). There was documentation that Staff A's TB skin test was to be read on 05/21/21 was read as negative [illegible] of the LHD.	C 140	Going forward all new hire will receive TB skin Test before working and staff will receive the test from medical Facility Lori Murphy 9-1-2022	

[illegible] Lori Murphy Owner / Administrator 9-1-2022

[illegible] (X6) DATE

Reviewed and Acknowledged Penny Katzlaff, RN 09/02/2022

FORM CMS-2567(02-99) Previous Versions Obsolete [illegible] If continuation sheet 1 of 22

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C 140	Continued From page 1 -There was documentation that Staff A received a second TB skin test on 10/27/21 at the facility, no time noted, by a registered nurse (RN) that the Administrator used to administer staff TB skin tests -There was documentation that Staff A's second TB skin test that was administered on 10/27/21 was read on 10/29/21 as 0mm, no time noted, by the RN that administered the test on 10/27/21 -There was no documentation that Staff A received a TB skin test upon hire Interview with Staff A on 08/02/22 at 12 34pm revealed -She started working at the facility in January 2021 as a MA -She received her first TB skin test at the LHD. -She received her second TB skin test from the RN that came to the facility to administer TB skin tests to staff members Interview with the Administrator on 08/02/22 at 3 05pm revealed -A registered nurse (RN) came out to the facility to administer tuberculosis (TB) skin tests to employees -The Administrator provided the solution to the RN that was needed to perform the TB skin tests -She obtained the solution needed to perform the TB skin tests from the facility's contracted pharmacy -The solution was kept at another facility and was brought over by her when it was needed to administer TB skin tests to employees Telephone interview with the registered nurse (RN) on 08/02/22 at 2 58pm revealed -She administered TB skin tests for many employees at the facility -The Administrator provided the solution for her to	C 140		

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C 140	Continued From page 2 use to perform the TB skin tests -She did not keep records of who she administered TB skin tests to but provided documentation to the facility when she performed a TB skin test on an employee Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/02/22 at 2 10pm revealed -A bottle of Tuberculin Purified Protein Derivative (PPD) was dispensed to the facility on 10/29/21 (Tuberculin PPD is injected under the skin and is used to help diagnose tuberculosis infections) -There were no other bottles of Tuberculin PPD dispensed to the facility.	C 140		
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 1 of 3 sampled staff (Staff A) received a criminal background check upon hire The findings are Review of Staff A's personnel record revealed -She was hired as a medication aide (MA) on 01/22/21 -A criminal background check was performed on Staff A on 11/03/21	C 147	Going forward all new hire will have criminal background check before working for LandC 9-1-2022 Tyra Murphy	

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C 147	Continued From page 3 -There was no record of a criminal background check being performed on Staff A prior to 11/03/21 Interview with the Administrator on 08/02/22 at 3 05pm revealed she did not onginally know that a criminal background check was needed when someone was hired at the facility and when she realized it, she ran a criminal background check on Staff A	C 147		
C 330	10A NCAC 13G 1004(a) Medication Administration 10A NCAC 13G 1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with (1) orders by a licensed prescribing practitioner which are maintained in the resident's record, and (2) rules in this Section and the facility's policies and procedures This Rule is not met as evidenced by Based on observations, interviews, and record reviews the facility failed to ensure medications were administered as ordered to 1 of 3 residents sampled (#1) for a medication used to treat anxiety The findings are 1 Review of Resident #1's current FL-2 dated 03/25/22 revealed -Diagnoses included insomnia, paranoid schizophrenia, and intellectual development disorder	C 330	All new hire must complete all medication hours of Training and pass the exam and be signed off by RN before passing meds 9-1-2022 Jess Murphy	

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C 330	Continued From page 4 -There was an order for Haldol 5mg three times a day (Haldol is an anti-psychotic medication used to treat mental/mood disorders such as schizophrenia and anxiety) Review of Resident #1's August 2022 medication administration record (MAR) on 8/02/22 at 8 59am revealed there was an entry for Haldol 5mg three times a day, scheduled for administration at 8 00am, 12 00pm, and 8 00pm Observation of Resident #1 s medication on hand on 08/02/22 at 1 45pm revealed there was Haldol 5mg in a medication pill package with a preprinted label from the pharmacy that had instructions to administer 1 tablet three times a day Interview with a resident on 08/02/22 at 11 45am revealed -Staff C had administered medication to him in -Staff C sometimes forgot to give his noon-time medication -He was unsure what the name of the noon-time medication was, but the medication was taken to help his nerves -He could tell when he missed a dose of the medication because he felt nervous and dizzy when he did not receive the medication Telephone interview with Staff C on 08/02/22 at 11 15am revealed -He was hired by the facility as a PCA (personal care aide) in January 2022 -He had never received any medication aide (MA) training -The Resident Care Coordinator (RCC) administered the resident's morning medications -The RCC pre-poured Resident #1 s noon-time medication in a cup and left it for him to	C 330		

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C 330	Continued From page 5 administer to the resident. -He administered Resident #1's 12 00pm medication that was placed in the cup by the RCC but sometimes he forgot to give the resident the medication. -The RCC and Administrator were aware that Resident #1 sometimes missed his 12:00pm medication because he would inform them when it happened. Interview with the Administrator on 08/02/22 at 12 48pm revealed -She was not aware Staff C gave medications -When the Administrator asked the RCC about pre-pouring medications for Staff C to administer to residents, she denied that she had prepared medications for him to administer -She knew that Staff C did not have MA training and she never asked him to pass medications because she had other staff that administered medications to residents. -She was under the assumption that the RCC passed all medications for the residents including morning, noon, and evening medications. -She was not aware that Resident #1 did not receive his 12:00pm scheduled dose of Haldol. Telephone interview with the facility's primary care provider (PCP) on 08/02/22 at 5 35pm revealed -She expected medication to be administered as ordered including Resident #1's Haldol that was scheduled three times a day -She was not aware that Resident #1 missed doses of his Haldol when Staff C would forget to administer the medication -It was concerning that medications were being administered by staff that were not trained to administer medications -Missing doses of Haldol might cause increased agitation or anxiety	C 330		

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C 330	Continued From page 6 Attempted telephone interview with the RCC on 08/02/22 at 2 21pm was unsuccessful 2 Review of Resident #1's current FL-2 dated 03/25/22 revealed there was an order for Ativan 1mg twice a day (Ativan is a medication used to treat anxiety). Review of Resident #1's August 2022 medication administration record (MAR) on 08/02/22 at 8 58am revealed -There was an entry for Ativan 1mg twice a day, scheduled for administration at 8 00am and 8 00pm -There was no documentation that Ativan 1mg was administered on 08/01/22 or 08/02/22 Observation of Resident #1's medications on hand on 08/02/22 at 1 45pm revealed there were 12 tablets in a medication packet label as Ativan 1 mg, to be administered twice a day Review of Resident #1's controlled substance log for Ativan 1mg revealed -Ativan 1mg was documented as given on 08/01/22 at 8 00 am, with a total of 12 tablets remaining -There was no documentation of Ativan being administered on 08/01/22 at 8 00pm and 08/02/22 at 8 00am Telephone interview with the facility's primary care provider (PCP) on 08/02/22 at 5 35pm revealed she expected all of Resident #1's medications to be administered as ordered	C 330		
C 342	10A NCAC 13G 1004(j) Medication Administration	C 342	Going forward all medications will be given within the	

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C 342	Continued From page 7 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 interviews and record reviews, the facility failed to ensure medication administration records (MAR) were complete and accurate for 3 of 3 residents (#1,#2 #3) sampled for two days of medication administration (08/01/22 and 08/02/22) The findings are 1. Review of Resident #1's current FL-2 dated 03/25/22 revealed -Diagnoses included insomnia, paranoid schizophrenia, and intellectual development disorder	C 342	3hrs undocumented on MAR if for any reason medication is MISSED or refused Dr. will be notified 9-1-2022 Tara Murphy	

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C 342	Continued From page 8 -There was an order for Cogentin 1mg twice a day (Cogentin is a medication used to treat involuntary movement due to the side effects of certain psychiatric medications) -There was an order for Carbamazepine 100mg twice a day (Carbamazepine is a medication used to used to treat seizures and mood disorders) -There was an order for Seroquel 100 mg daily (Seroquel is a medication used to treat schizophrenia) -There was an order for Seroquel 25mg at bedtime. -There was an order for Belsomra 10mg at bedtime (Belsomra is a medication used to treat insomnia) -There was an order for Haldol 5mg three times a day (Haldol is an anti-psychotic medication used to treat mental/mood disorders such as schizophrenia) -There was an order for Ativan 1mg twice a day (Ativan is a medication used to treat anxiety) Review of Resident #1's August 2022 medication administration record (MAR) on 08/02/22 at 8:58am revealed -There was an entry for Cogentin 1mg twice a day, scheduled for administration at 8:00am and 8:00pm -There was no documentation that Cogentin 1mg was administered on 08/01/22 and 08/02/22 -There was an entry for Carbamazepine 100mg twice a day, scheduled for administration at 8:00am and 8:00pm -There was no documentation that Carbamazepine 100mg was administered on 08/01/22 and 08/02/22 -There was an entry for Seroquel 100mg daily, scheduled for administration at 8:00am -There was no documentation that Seroquel 100mg was administered on 08/01/22 and	C 342		

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C 342	Continued From page 9 08/02/22. -There was an entry for Seroquel 25mg at bedtime, scheduled for administration at 8 00pm -There was no documentation that Seroquel 25mg was administered on 08/01/22 -There was an entry for Belsomra 10mg at bedtime, scheduled for administration at 8:00pm -There was no documentation that Belsomra 10mg was administered on 08/01/22 and 08/02/22. -There was an entry for Haldol 5mg three times a day, schedule for administration at 8 00am, 12 00pm, and 8 00pm -There was no documentation that Haldol 5mg was administered on 08/01/22 or 08/02/22 -There was an entry for Ativan 1mg twice a day, scheduled for administration at 8 00am and 8:00pm -There was no documentation that Ativan 1mg was administered on 08/01/22 or 08/02/22 Interview with Resident #1 on 08/02/22 at 12:15pm revealed he received his medication yesterday and today (08/01/22 and 08/02/22) from the Administrator Refer to interview with a medication aide (MA) on 08/02/22 at 12 34pm Refer to interview with the Administrator on 08/02/22 at 2 40pm 2. Review of Resident #2's current FL-2 dated 03/25/22 revealed -Diagnoses included chronic schizophrenia, personality disorder, borderline intellectual disability disorder, hypertension, vitamin-D deficiency, hemorrhoids, and bradycardia -There was an order for Clozapine 100mg daily (Clozapine is a medication used to treat	C 342		

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C 342	Continued From page 10 schizophrenia) -There was an order for Lisinopril 5mg daily (Lisinopril is a medication used to treat hypertension) -There was an order for Klonopin 1mg daily (Klonopin is a medication used to treat panic disorder and anxiety) -There was an order for Zyprexa 15mg daily (Zyprexa is a medication used to treat schizophrenia) -There was an order for Vitamin D3 2,000IU daily (Vitamin D3 is used to treat vitamin-D deficiency) -There was an order for Miralax 17gm daily (Miralax is a laxative used to treat constipation) -There was an order for Depakote 250mg three times a day (Depakote is a medication used to treat manic-depressive disorder) -There was an order for Klonopin 3mg at bedtime Review of Resident #2's August 2022 medication administration record (MAR) on 08/02/22 at 9:00am revealed -There was an entry for Clozapine 100mg daily, scheduled for administration at 8:00am -There was no documentation that Clozapine 100mg was administered on 08/01/22 and 08/02/22 -There was an entry for Lisinopril 5mg daily, scheduled for administration at 8:00am -There was no documentation that Lisinopril 5mg was administered on 08/01/22 and 08/02/22 -There was an entry for Klonopin 1mg daily, scheduled for administration at 8:00am -There was no documentation that Klonopin 1mg was administered on 08/01/022 and 08/02/22 -There was an entry for Zyprexa 15mg daily, scheduled for administration at 8:00am -There was no documentation that Zyprexa 15mg was administered on 08/01/22 and 08/02/22 -There was an entry for Vitamin D3 2,000IU daily,	C 342		

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C 342	Continued From page 11 scheduled for administration at 8 00am -There was no documentation that Vitamin D3 2,000IU was administered on 08/01/22 and 08/02/22 -There as an entry for Miralax 17gm daily, scheduled for administration at 8 00am -There was no documentation that Miralax 17gm was administered on 08/01/22 and 08/02/22 -There was an entry for Depakote 250mg three times a day, scheduled for administration at 8 00am, 2 00pm, and 8 00pm -There was no documentation that Depakote 250mg was administered on 08/01/22 and 08/02/22 -There was an entry for Klonopin 3mg at bedtime, scheduled for administration at 8 00pm -There was no documentation that Klonopin 3mg was administered on 08/01/22 Refer to interview with a medication aide (MA) on 08/02/22 at 12 34pm Refer to interview with the Administrator on 08/02/22 at 2 40pm Based on observation, interviews, and record reviews, it was determined that Resident #2 was not interviewable 3 Review of Resident #3's current FL-2 dated 12/28/21 revealed -Diagnoses included schizophrenia, diabetes type 2 and hypertension -There was an order for Januvia 100mg daily (Januvia is a medication used to treat symptoms of diabetes) -There was an order for Glipizide XL 5mg daily (Glipizide is a medication used to treat symptoms of diabetes) -There was an order for Atenolol 25mg daily	C 342		

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C 342	Continued From page 12 (Atenolol is a medication used to treat hypertension) -There was an order for Lisinopril 20mg daily (Lisinopril is a medication used to treat hypertension) -There was an order for Farxiga 10mg daily (Farxiga is a medication used to treat symptoms of diabetes) -There was an order for Aspirin 81mg daily (Aspinn is an anti-inflammatory medication) -There was an order for Omeprazole 40mg daily (Omeprazole is a medication used to treat gastric reflux) -There was an order for Cogentin 1mg daily (Cogentin is a medication used to treat involuntary movement due to the side effects of certain psychiatric medications) -There was an order for Metformin ER (extended-release) 1,000mg twice a day (Metformin is a medication used to treat symptoms of diabetes) -There was an order for Fish Oil 1,000mg twice a day (Fish Oil is a supplement used to decrease the risk of cardiovascular disease) -There was an order for Lipitor 10mg at bedtime (Lipitor is a medication used treat high cholesterol) -There was an order for Depakote 250mg every morning (Depakote is a medication used to treat manic-depressive disorder) -There was an order for Depakote 500mg every evening -There was an order for Hydroxyzine 50mg at bedtime (Hydroxyzine is an antihistamine used in the treatment of anxiety) Review of Resident #3's August 2022 medication administration record (MAR) on 08/02/22 at 8:56am revealed -There was an entry for Januvia 100mg daily.	C 342		

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C 342	Continued From page 13 scheduled for administration at 8 00am -There was no documentation that Januvia 100mg was administered on 08/01/22 and 08/02/22 -There was an entry for Glipizide 5mg daily, scheduled for administration at 8 00am -There was no documentation that Glipizide 5mg was administered on 08/01/22 and 08/02/22 -There was an entry for Atenolol 25mg daily scheduled for administration at 8 00am -There was no documentation that Atenolol 25mg was administered on 08/01/22 and 08/02/22 -There was an entry for Lisinopril 20mg daily, scheduled for administration at 8 00am -There was no documentation that Lisinopril 20mg was administered on 08/01/22 and 08/02/22 -There was an entry for Farxiga 10mg daily, scheduled for administration at 8 00am -There was no documentation that Farxiga 10mg was administered on 08/01/22 and 08/02/22 -There was an entry for Aspirin 81mg daily, scheduled for administration at 8 00am -There was no documentation that Aspirin 81mg was administered on 08/01/22 and 08/02/22 -There was an entry for Omeprazole 40mg daily, scheduled for administration at 8 00am -There was no documentation that Omeprazole 40mg was administered on 08/01/22 and 08/02/22 -There was an entry for Cogentin 1mg daily, scheduled for administration at 8 00am -There was no documentation that Cogentin 1mg was administered on 08/01/22 and 08/02/22 -There was an entry for Metformin ER 1,000mg, scheduled for administration at 8 00am and 8 00pm -There was no documentation that Metformin ER 1,000mg was administered on 08/01/22 and 08/02/22	C 342		

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	FCL074050	A. BUILDING _____ B. WING _____	R 08/02/2022

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C 342	Continued From page 14 -There was an entry for Fish Oil 1,000mg twice a day, scheduled for administration at 8:00am and 8:00pm -There was no documentation that Fish Oil 1,000mg was administered on 08/01/22 and 08/02/22 -There was an entry for Lipitor 10mg at bedtime, scheduled for administration at 8:00pm -There was no documentation that Lipitor 10mg was administered on 08/01/22 -There was an entry for Depakote 250mg every morning, scheduled for administration at 8:00am -There was no documentation that Depakote 150mg was administered on 08/01/22 and 08/02/22 -There was an entry for Depakote 500mg every evening, scheduled for administration at 8:00pm -There was no documentation that Depakote 500mg was administered on 08/01/22 -There was an entry for Hydroxyzine 50mg at bedtime, scheduled for administration at 8:00pm -There was no documentation that Hydroxyzine 50mg was administered on 08/01/22 Interview with Resident #1 on 08/02/22 at 12:15pm revealed he received his medication yesterday and today (08/01/22 and 08/02/22) from the Administrator Refer to interview with a medication aide (MA) on 08/02/22 at 12:34pm Refer to interview with the Administrator on 08/02/22 at 2:40pm --- Interview with a medication aide (MA) on 08/02/22 at 12:34pm revealed -When medications were administered, it was the responsibility of the person administering the medications to sign off on the resident's	C 342		

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C 342	Continued From page 15 medication administration record (MAR) -It was expected that you sign off on the MAR immediately after administering medications Interview with the Administrator on 08/02/22 at 2 40pm -She was responsible for administering medications to the residents on 08/01/22 and 08/02/22 -All residents received their ordered medications on 08/01/22 and 08/02/22 -It was expected that MAR were complete and accurate, and filled out immediately after administration -She did not sign off on the residents MAR because she was busy working on new admission paperwork for her other family care home	C 342		
C 912	G S 131D-21(2) Declaration of Residents' Rights G S 131D-21 Declaration of Resident's Rights Every resident shall have the following rights 2 To receive care and services which are adequate appropriate, and in compliance with relevant federal and state laws and rules and regulations This Rule is not met as evidenced by Based on interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Adult Care Home Medication Aides Training and Competency The findings are	C 912		

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C 912	Continued From page 16 Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) who administered medications had completed medication aide training, including the 5, 10, or 15-hour medication aide training course, the clinical skills checklist, and a competency evaluation before administering medications [Refer to Tag 0935 G S. 131D-4.5(B)(b) ACH Medication Aides' Training and Competency (Type B Violation)]	C 912	All new hire must complete all medication hours, training course and clinical checklist and competency evaluation pass med exam and be checked off by RN 9-1-2022 Lisa Murphy	
C935	G.S § 131D-4 5B (b) ACH Medication Aides,Training and Competency G S § 131D-4 5B (b) Adult Care Home Medication Aides, Training and Competency Evaluation Requirements (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following (1) A five-hour training program developed by the Department that includes training and instruction in all of the following a The key principles of medication administration b The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists (2) A clinical skills evaluation consistent with 10A NCAC 13F 0503 and 10A NCAC 13G 0503 (3) Within 60 days from the date of hire, the	C935	All new hire will receive medication training, clinical skill evaluation within 60 days of hire all training will be done by RN 9-1-2022 Lisa Murphy	

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C935	Continued From page 17 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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) who administered medications had completed medication aide training, including the 5, 10, or 15-hour medication aide training course and the medication clinical skills validation checklist prior to administering medications The findings are Review of Staff C's personnel record revealed -He was hired as a personal care aide (PCA) on 01/11/22 -There was no documentation of medication aide employment verification, a 5, 10, or 15- hour medication aide training course, a medication clinical skills validation checklist, or a medication examination for Staff C Interview with a resident on 08/02/22 at 11 45am revealed	C935		

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C935	Continued From page 18 -Staff C had administered medication to him -Staff C sometimes forgot to give his noon-time medication -He was unsure what the name of the noon-time medication was, but the medication was taken to help his nerves -He could tell when he missed a dose of the noon-time medication because he felt nervous and dizzy when he did not receive the medication. Interview with a second resident on 08/02/22 at 11:47am revealed Staff C sometimes gave medications to him in the afternoons and evenings. Telephone interview with Staff C on 08/02/22 at 11:15am revealed. -He was hired by the facility as a PCA in January 2022 -He had never received any medication aide (MA) training -The Resident Care Coordinator (RCC) administered the resident's morning medications. -The RCC pre-poured a resident's noon-time medication in a cup and left it for him to administer to the resident -He administered the resident's noon-time medication that was placed in the cup by the RCC but sometimes he forgot to give the resident the medication -The RCC also pre-poured all the resident's evening medications by placing them in cups for him to administer to the residents -In the evening he administered the medications that the RCC had pre-poured in the cups for the residents -In February 2022 the RCC was not working so a MA came to the facility and pre-poured the noon-time and evening medications in cups for him to administer to the residents	C935		

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C935	Continued From page 19 -He administered the medications as they were pre-poured by the MA. -He did not document on the medication administration records (MAR) when he administered medications to residents Interview with the MA on 08/02/22 at 12.34pm revealed she had never pre-poured medications for someone else to administer. Interview with the Administrator on 08/02/22 at 12.48pm revealed. -She was not aware that Staff C was administering medications to residents. -When she asked the RCC about pre-pouring medications for Staff C to administer to residents, she denied that she had prepared medications for him to administer -The RCC passed morning medications as well as noon and evening medications. -If the RCC was not available then another MA would come to the facility and administer medications to the residents. -The RCC was no longer employed at the facility -All the keys for the facility, including the key to the medication cart, were kept in the staff room and all employees had access to all the keys Telephone interview with the facility's primary care provider (PCP) on 08/02/22 at 5.35pm revealed -It was concerning that medications were being administered by staff that were not trained to administer medications -If residents missed medication doses or received incorrect medications it could cause them to have adverse reactions Attempted telephone interview with the RCC on 08/02/22 at 2.21pm was unsuccessful	C935		

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C935	Continued From page 20 The facility failed to ensure Staff C who administered pre-poured medications to residents had completed the medication aide training and competency evaluation before administering medications including the 5, 10, or 15-hour medication aide training course and the medication clinical skills validation checklist. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G S 131D-34 on 08/02/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 16, 2022.	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	C992	All employee will be drug tested upon hiring if controlled substances are positive new hire must have a Dr list all medication new hire is taking 9-1-2022 Jessa Murphy	

Division of Health Service Regulation

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C992	Continued From page 21 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 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 1 out of 3 sampled staff (Staff A) received a drug screen upon hire. The findings are: Review of Staff A's personnel record revealed: -She was hired as a medication aide (MA) on 01/22/21. -A drug screen was completed on Staff A on 11/02/21. -There was no record of a drug screen being completed on Staff A prior to 11/02/21. Interview with the Administrator on 08/02/22 at 3:05pm revealed she did not originally know that a drug screen was needed when someone was hired at the facility and when she realized it, she did a drug screen on Staff A.	C992		