

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL013046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/01/2022
NAME OF PROVIDER OR SUPPLIER KANNAPOLIS FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2216 KANNAPOLIS HIGHWAY CONCORD, NC 28027		
(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 and the Cabarrus County DSS conducted a follow-up and annual survey on 09/01/22.	C 000		
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, records reviews, and interviews, the facility failed to administer medications as ordered by the prescribing practitioner for 1 of 3 sampled residents (#3) related to a medication used to treat seizures and a medication used to treat inflammation. The findings are: Review of Resident #3's current FL2 dated 04/08/22 revealed: -Diagnoses included epilepsy. -An order for clobazam 10mg (a medication used to treat seizures) at night. a. Review of Resident #3's Primary Care Provider (PCP) orders dated 07/18/22 revealed an order for clobazam 10mg before bedtime as needed.	C 330	1.1 - Staff have been re-trained on ensuring that the medication orders and the medications available match to include strength, dosage, quantity and time. The facility RN has worked with staff on ensuring that the medication dose packs match the medications orders on the smar. If staff do not have	10-16-22

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

L4CE11

If continuation sheet 1 of 16

Reviewed and acknowledged on 10/06/22

by

DMS

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C 330	Continued From page 1 Review of Resident #3's July 2022 electronic medication administration record (eMAR) revealed: -An entry for clobazam 10mg daily at bedtime, scheduled for 8:00pm with a stop date of 07/29/22. -Clobazam 10mg scheduled at bedtime was documented as administered from 07/01/22 to 07/28/22 at 8:00pm. -An entry for clobazam 20mg daily at bedtime, scheduled for 8:00pm with a start date of 07/29/22. -Clobazam 20mg scheduled at bedtime was documented as administered from 07/29/22 to 07/31/22. -An entry for clobazam 20mg half tablet (10mg) once at bedtime as needed. -Clobazam 20mg half tablet scheduled at bedtime as needed was not documented as administered from 07/01/22 to 07/31/22. Review of Resident #3's August 2022 eMAR revealed: -An entry for clobazam 20mg at bedtime, scheduled at 8:00pm. -Clobazam 20mg scheduled at bedtime was documented as administered from 08/01/22 to 08/27/22 and on 08/30/22. -Clobazam 20mg scheduled at bedtime was not documented as administered on 08/28/22, 08/29/22 and 08/31/22 due to awaiting a refill. -An entry for clobazam 20mg half tablet (10mg) at bedtime as needed. -Clobazam 20mg half tablet scheduled at bedtime as needed was not documented as administered from 08/01/22 to 08/31/22. Review of Resident #3's September 2022 eMAR revealed: -An entry for clobazam 20mg once at bedtime,	C 330	the medications to be given they are to notify the pharmacy, the facility RN and administrator. Staff have also been trained on calling the MD if the patient has not received medications due to armed not in the facility or waiting on order clarification	10-16-22	

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C 330	Continued From page 2 scheduled at 8:00pm. -Clobazam 20mg scheduled for bedtime was not documented as administered on 09/01/22. -An entry for clobazam 20mg half tablet (10mg) at bedtime as needed. -Clobazam 20mg half tablet scheduled at bedtime as needed was not documented as administered on 09/01/22. Observation of Resident #3's medications on hand on 09/01/22 at 2:49pm revealed: -Clobazam 10mg was not available to administer. -Clobazam 20mg half tablets (10mg) were not available to administer. -Clobazam 20mg was not available to administer. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 3:07pm revealed: -The pharmacy did not have an order for clobazam 20mg daily at bedtime. -The Pharmacist thought clobazam 20mg could have been entered on the eMAR by mistake after receiving an email from the facility to inquire about the order. -Thirty tablets of clobazam 10mg were dispensed on 07/07/22, which should have run out on 08/07/22. -Fifteen halved tablets of clobazam 20 mg were dispensed on 07/19/22, for the bedtime as needed dose, which would have been 30 doses. Interview with the medication aide (MA) on 09/01/22 at 4:15pm revealed: -She received some training from another MA at the facility on how to administer medications. -Her initials were on the eMAR in August 2022 for administering clobazam 20mg at bedtime.	C 330	1.2 Measure put in place to prevent: Facility RN has been checking charts, eMAR and med pass daily. Facility RN or administrator will continue to check charts, eMAR and med passes weekly to ensure Policy & procedure followed	10-16-22	

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C 330	Continued From page 3 -She thought she checked of all medications listed on the eMAR with the medication labels from the pharmacy to ensure they matched before administering the medication to the residents. -She could not remember if she checked the dose of the clobazam medication label with the August 2022 eMAR before it was administered to Resident #3. Refer to the interview with the Administrator on 09/01/22 at 4:20pm. b. Review of Resident #3's Primary Care Provider's (PCP) orders dated 07/08/22 revealed an order for celecoxib 200 mg (a medication used to treat inflammation) once daily. Review of Resident #3's July 2022 eMAR revealed: -An entry for celecoxib 200mg once daily, scheduled at 9:00am with a stop date of 07/11/22. -Celecoxib 200mg was documented as administered from 07/09/22 to 07/11/22. -An entry for celecoxib 100mg once daily, scheduled at 9:00am with an order written date of 07/11/22. -Celecoxib 100mg was documented as administered from 07/12/22 to 07/31/22. Review of Resident #3's August 2022 eMAR revealed: -An entry for celecoxib 100mg once daily, scheduled for 9:00am. -Celecoxib 100mg was documented as administered from 08/01/22- 08/31/22. Review of Resident #3's September 2022 eMAR revealed: -An entry for celecoxib 100mg once daily,	C 330	1.3 - Facility RN or administrator will monitor situation. 1.4 - Monitoring has been occurring daily, but will continue weekly.	10-16-22 10-16-22

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C 330	Continued From page 4 scheduled for 9:00am. -Celecoxib 100mg was not documented as administered on 09/01/22 with a comment that stated "withheld per Doctor/Registered Nurse orders". Observation of Resident #3's medications on hand on 09/01/22 at 2:49pm revealed celecoxib was not available to administer. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 3:07pm revealed: -The order for celecoxib 100mg was written on 07/11/22 by Resident #3's PCP. -A one-week supply of celecoxib 100mg was dispensed on 07/11/22, 07/18/22 and 07/25/22 in the multidose medication packages (21 doses). -Celecoxib 100mg was not dispensed after 07/25/22 due to an email that they pharmacy received from the facility. -Resident #3 should have run out of celecoxib 100mg on 07/31/22. Interview with the MA on 09/01/22 at 10:30am revealed: -She was not aware that the pharmacy did not send Resident #3's celecoxib in the multidose medication packages in August 2022. -She looked at the medication package and the eMAR to verify the medication but did not count the pills in the package. -She was not taught to count the number of pills in the multidose package before administering the medications. Refer to the interview with the Administrator on 09/01/22 at 4:20pm.	C 330		

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C 330	Continued From page 5 Interview with the Administrator on 09/01/22 at 4:20pm revealed: -The MA should have called the pharmacy when clobazam 20mg appeared on the eMAR and the facility did not have the medication to administer. -The MA should have identified the pills in the multidose medication packages and contacted the pharmacy to inquire why the celecoxib 100mg was not delivered. -She audited the resident's records at the end of every month and compared the medication orders to the medications in the facility. -She did not have time to audit the resident's records in August 2022. -She was not aware that the pharmacy never dispensed clobazam 20mg. -She was not aware Resident #3 went the entire month of August 2022 without celecoxib. Attempted telephone interview with Resident #3's PCP on 09/01/22 at 3:38pm was unsuccessful. Attempted telephone interview with Resident #3's family member on 09/01/22 at 4:15pm was unsuccessful. Based on interviews and observations it was determined that Resident #3 was uninterviewable.	C 330			
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;	C 342			

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C 342	Continued From page 6 (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, record reviews and interviews, the facility failed to ensure the accuracy of the medication administration record for 1 of 3 sampled residents (#3), including a medication used to treat seizures and a medication used to treat inflammation. The findings are: Review of Resident #3's current FL2 dated 04/08/22 revealed: -Diagnoses included epilepsy. -An order for clobazam 10mg at bedtime. a. Review of Resident #3's Primary Care Provider's (PCP) orders dated 07/18/22 revealed an order for clobazam 10mg before bedtime as needed.	C 342			

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C 342	Continued From page 7 Review of Resident #3's July 2022 electronic medication administration record (eMAR) revealed: -An entry for clobazam 10mg daily at bedtime, scheduled for 8:00pm with a stop date of 07/29/22. -Clobazam 10mg scheduled at bedtime was documented as administered from 07/01/22 to 07/28/22 at 8:00pm. -An entry for clobazam 20mg daily at bedtime, scheduled for 8:00pm with a start date of 07/29/22. -Clobazam 20mg scheduled at bedtime was documented as administered from 07/29/22 to 07/31/22. -An entry for clobazam 20mg half tablet (10mg) once at bedtime as needed. -Clobazam 20mg half tablet scheduled at bedtime as needed was not documented as administered from 07/01/22 to 07/31/22. Review of Resident #3's August 2022 eMAR revealed: -An entry for clobazam 20mg at bedtime, scheduled at 8:00pm. -Clobazam 20mg scheduled at bedtime was documented as administered from 08/01/22 to 08/27/22 and on 08/30/22. -Clobazam 20mg scheduled at bedtime was not documented as administered on 08/28/22, 08/29/22 and 08/31/22 with the comment "awaiting a refill". -An entry for clobazam 20mg half tablet (10mg) at bedtime as needed. -Clobazam 20mg half tablet scheduled at bedtime as needed was not documented as administered from 08/01/22 to 08/31/22. Review of Resident #3's September 2022 eMAR revealed: -An entry for clobazam 20mg once at bedtime,	C 342		

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C 342	Continued From page 8 scheduled at 8:00pm. -Clobazam 20mg scheduled for bedtime was not documented as administered on 09/01/22. -An entry for clobazam 20mg half tablet (10mg) at bedtime as needed. -Clobazam 20mg half tablet scheduled at bedtime as needed was not documented as administered on 09/01/22. Observation of Resident #3's medications on hand on 09/01/22 at 2:49pm revealed: -Clobazam 10mg was not available to administer. -Clobazam 20mg half (10mg) tablets were not available to administer. -Clobazam 20mg was not available to administer. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 3:07pm revealed: -The pharmacy did not have an order for clobazam 20mg daily at bedtime. -The Pharmacist thought clobazam 20mg could have been entered on the eMAR by mistake after receiving an email from the facility to inquire about the order. -Thirty tablets of clobazam 10mg were dispensed on 07/07/22, which should have run out on 08/07/22. -Fifteen halved tablets of clobazam 20 mg were dispensed on 07/19/22, for the bedtime as needed dose, which would have been 30 doses. Interview with the medication aide (MA) on 09/01/22 at 4:15pm revealed: -Her initials were on the eMAR in August 2022 for administering clobazam 20mg at bedtime. -She could not remember if she checked the dose of the clobazam medication label with the eMAR	C 342		

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C 342	Continued From page 9 before it was administered to Resident #3 but documented that it was administered on the August 2022 eMAR. -She was not aware that the order on the August 2022 eMAR was for clobazam 20mg and the medication label did not match the eMAR. Refer to the interview with the Administrator on 09/01/22 at 4:20pm. b. Review of Resident #3's Primary Care Provider's (PCP) orders dated 07/08/22 revealed an order for celecoxib 200 mg once daily. Review of Resident #3's July 2022 eMAR revealed: -An entry for celecoxib 200mg once daily, scheduled at 9:00am with a stop date of 07/11/22. -Celecoxib 200mg was documented as administered from 07/09/22 to 07/11/22. -An entry for celecoxib 100mg once daily, scheduled at 9:00am with an order written date of 07/11/22. -Celecoxib 100mg was documented as administered from 07/12/22 to 07/31/22. Review of Resident #3's August 2022 eMAR revealed: -An entry for celecoxib 100mg once daily, scheduled for 9:00am. -Celecoxib 100mg was documented as administered from 08/01/22 to 08/31/22. Review of Resident #3's September 2022 eMAR revealed: -An entry for celecoxib 100mg once daily, scheduled for 9:00am. -Celecoxib 100mg was not documented as administered on 09/01/22 due to "withheld per	C 342			

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C 342	Continued From page 10 Doctor/Registered Nurse orders". Observation of Resident #3's medications on hand on 09/01/22 at 2:49pm revealed celecoxib was not available to administer. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/01/22 at 3:07pm revealed: -The order for celecoxib 100mg was written on 07/11/22 by Resident #3's PCP. -A one-week supply of celecoxib 100mg was dispensed on 07/11/22, 07/18/22 and 07/25/22. -Celecoxib 100mg was not dispensed after 07/25/22 due to an email that they pharmacy received from the facility. -Resident #3 should have run out of celecoxib 100mg on 07/31/22. Interview with the MA on 09/01/22 at 10:30am revealed: -She was not aware that the pharmacy did not send Resident #3's celecoxib in the multidose medication packages in August 2022. -She documented celecoxib as administered to Resident #3 on the August 2022 eMAR because she thought the medication was included in the multidose package. Refer to the interview with the Administrator on 09/01/22 at 4:20pm. Interview with the Administrator on 09/01/22 at 4:20pm revealed: -The clobazam 20mg and celecoxib 100mg should not have been documented as administered on the eMAR since the facility did not have those medications.	C 342			

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C 342	Continued From page 11 -She audited the resident's records at the end of every month and compared the medication orders to the medications in the facility. -She did not have time to audit the resident's records in August 2022. -She was not aware Resident #3's clobazam and celecoxib were being documented as administered when the medications were not in the facility. Attempted telephone interview with Resident #3's PCP on 09/01/22 at 3:38pm was unsuccessful. Attempted telephone interview with Resident #3's family member on 09/01/22 at 4:15pm was unsuccessful. Based on interviews and observations it was determined that Resident #3 was uninterviewable.	C 342			
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.	C935	1.1. The facility 8/16-22 RN has been with the MA passing medications. Moving forward this will be practice until the MA hired has passed the med/hel		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

KANNAPOLIS FAMILY CARE HOME

**2216 KANNAPOLIS HIGHWAY
CONCORD, NC 28027**

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C935	Continued From page 12 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: TYPE B VIOLATION Based on interviews, and record reviews the facility failed to ensure 1 of 1 sampled staff (Staff A) who administered medications had completed 10/15 hours of Medication Aide (MA) Training, the written MA exam prior to administering medications, and was not being supervised by another MA. The findings are: 1. Review of Staff A's medication aide (MA) personnel record revealed: -Staff A was hired on 08/01/22. -There was no documentation she passed the	C935	test & had 10 hour training. Facility has always hired clone 5 hour / checklist / supervision & test within 60 days & 10 hour with 60 days of hire but will & has changed that practice immediately. MA's passing medications	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL013046	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/01/2022
NAME OF PROVIDER OR SUPPLIER KANNAPOLIS FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2216 KANNAPOLIS HIGHWAY CONCORD, NC 28027			
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C935	Continued From page 13 written MA exam. -There was no documentation she completed the 10/15-hour training. -There was documentation she completed the 5-hour MA training on 07/27/22. -There was no documentation she completed the 10/15 hour MA training. -There was no documentation she worked as a MA in the past 24 months. Review of a resident's August 2022 electronic Medication Administration Record (eMAR) revealed Staff A documented administering medications every day except 08/08/22, 08/11//22 to 08/14/22 and 08/22/22 to 08/28/22. Review of a resident's September 2022 electronic Medication Administration Record (eMAR) revealed Staff A documented administering medications on 09/01/22. Observation of the MA administering a residents medications on 09/01/22 at 10:25am revealed: -The MA was documenting medications on the eMAR, then emptying the multi-dose pack and administering the medications. -The MA did not confirm the medications in the multi-dose pack matched the eMAR. -The MA documented on 7 different medications as administered for a resident, then emptied all the contents from the resident's multi-dose pack into the medication cup. -The MA did not count the medications and proceeded to the resident to administer the medications. -The MA was prompted to stop and count the medications in the medication cup. -There were 7 medications (12-1/2 tablets) entered	C935	will have all requirements or will be supervised by another med tech or facility RN 1.2 The requirements for the med tech will be met at hire date to appropriate plan.	10-16-22	

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C935	Continued From page 14 on the eMAR to be administered according to the eMAR. -The MA only had 8-1/2 tablets in a medication cup to administer to the resident. -There were 4 tablets that were not administered that she documented on the eMAR as administered. Interview with the MA on 09/01/22 at 10:30am revealed: -She was hired as a MA on 08/01/22. -She was not a MA prior to working at the facility. -She completed the required 5-hour medication aide training and the medication skills check list on 07/25/22. -She did not take the MA test or complete the required 10-hour MA training. -She administered medications for the past 3 weeks. -She stayed at the facility 24 hours a day for the past 2 weeks without anyone there with her to supervise her when she administered medications, since she started working as a MA on 08/01/22. -She asked the Administrator several times a day asking for help with medication administration due to the resident care case load. -She did not receive help with medications. -She did not know she was to complete the 10-hour MA training and MA test prior to administering medications without another MA supervising her. Interview with the Administrator on 09/01/22 at 11:20am revealed: -The MA was hired on 08/01/22 and received her 5-hour MA training and the MA clinical skills check list on 07/27/22 prior to administering medications on 08/01/22.	C935	1.3 - Facility RN, administrator & administrator assistant will ensure these qualifications are met at hire date & have a plan for supervision if not. 1.4 - at hire & continuous until requirements met.	10-16-22 10-16-22	

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C935	Continued From page 15 -She did not know MAs were not allowed to administer medications without supervision until after the MA had completed the 5/10 or 15-hour medication, the clinical skills check list and the MA test before a MA could administer medications without supervision. The facility failed to ensure Staff A successfully completed the 10, or 15 medication class, the medication clinical skills validation portion of the competency evaluation, or the medication examination prior to the administration of medications, resulted in Staff A administering medications without verifying the correct medications were administered to the residents. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility did not provide a Plan of Protection in accordance with G.S. 131D-34. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 16, 2022.	C935			