STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035028	A. BUILDING: _____ B. WING _____	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER HEALTHCARE #1	306 LUMPKIN BLVD LOUISBURG, NC 27549

(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 November 22, 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 record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (A) was tested for Tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Public Health. The findings are: Review of Staff A's, supervisor-in-charge (SIC) personnel record revealed: -She was hired to work at the facility on 03/02/20. -There was documentation of a TB skin test read as negative on 03/02/20. -There was no documentation of any other TB skin test for Staff A after the hire date of 03/02/20.	C 140		

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C 140	Continued From page 1 Interview with Staff A on 11/22/22 at 2:20pm revealed: -She had a TB skin test when she was hired in 2020. -She did not have a second TB skin test completed after she was hired. -She was not told to have a second TB skin test completed by the Resident Care Coordinator (RCC) or the Administrator. Interview with the RCC on 11/22/22 at 2:57pm revealed: -She did not know Staff A did not have a second TB skin test after she was hired. -The Administrator had access to the personnel records and she did not review the personnel record. Telephone interview with the Administrator on 11/22/22 at 4:15pm revealed: -She did not know Staff A did not have a second TB skin test. -She was responsible for checking staff qualifications, but she had not been able to check the personnel records for months. -She had not told Staff A to obtain a second TB skin test after her hire date of 03/02/20. -She was responsible for personnel records and assuring staff had two TB skin tests on file.	C 140		
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 2 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure blood pressure (BP) checks were implemented and documented as ordered for 2 of 3 sampled residents with orders for monthly BP checks (Resident #1 and #2). The findings are: 1. Review of Resident #1's current FL-2 dated 04/21/22 revealed: -Diagnoses included hypertension, hyperlipidemia, chronic obstructive pulmonary disease (COPD), depression, and schizophrenia. -There was an order for monthly blood pressure (BP) monitoring. Review of Resident #1's September 2022 printed medication administration record (MAR) revealed: -There was no entry to check blood pressure. -There was no blood pressure reading documented. -There were no other blood pressure readings documented on the reverse side of the September 2022 MAR. Review of Resident #1's October 2022 MAR revealed: -There was no entry to check blood pressure. -There was no blood pressure reading documented. -There were no other blood pressure readings documented on the reverse side of the October 2022 MAR.	C 249		

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C 249	Continued From page 3 Review of Resident #1's November 2022 MAR revealed: -There was no entry to check blood pressure. -There was a blood pressure reading of 106/66 documented within a blank space on the MAR. -There were no other blood pressure readings documented on the reverse side of the November 2022 MAR. Observation of Resident #1 on 11/22/22 at 4:40pm revealed the Resident Care Coordinator (RCC) obtained Resident #1's BP and Resident #1's BP was 103/80. Interview with Resident #1 on 11/22/22 at 8:15am revealed: -She had her BP monitored weekly along with her weight and temperature. -She thought that she did not take any medications for hypertension. Interview with a MA on 11/22/22 at 2:20pm revealed: -She did not know Resident #1 had an order on her current FL-2 for monthly BP monitoring. -The RCC, Administrator or a MA reviewed FL-2s and any orders from the primary care provider (PCP). -She had not reviewed Resident #1's FL-2. -She was not told Resident #1 had monthly BP monitoring. -Resident #1's monthly BP was not on the MAR, so she did not know to obtain Resident #1's BP. Attempted telephone interview with Resident #1's PCP's office on 11/22/22 at 1:56pm. Refer to the interview with the RCC on 11/22/22 at 2:57pm.	C 249		

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C 249	Continued From page 4 Refer to the telephone interview with the Administrator on 11/22/22 at 4:15pm. 2. Review of Resident #2's current FL-2 dated 07/29/22 revealed: -Diagnoses included hypertension, arthritis, gastro-esophageal reflux disease (GERD) and bipolar disorder. -There was an order for monthly blood pressure (BP) monitoring. Review of Resident #2's September 2022 medication administration record (MAR) revealed: -There was no entry to check blood pressure. -There was no blood pressure reading documented. -There were no other blood pressure readings documented on the reverse side of the September 2022 MAR. Review of Resident #2's October 2022 MAR revealed: -There was no entry to check blood pressure. -There was no blood pressure reading documented. -There were no other blood pressure readings documented on the reverse side of the October 2022 MAR. Review of Resident #2's November 2022 MAR revealed: -There was no entry to check blood pressure. -There was a blood pressure reading of 106/63 documented within a blank space on the MAR. -There were no other blood pressure readings documented on the reverse side of the November 2022 MAR. Observation of Resident #2 on 11/22/22 at 4:11pm revealed the Resident Care Coordinator	C 249		

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C 249	Continued From page 5 (RCC) obtained Resident #2's BP and Resident #2's BP was 110/64. Interview with a medication aide (MA) on 11/22/22 at 2:20pm revealed: -She did not know Resident #2 had an order on her current FL-2 for monthly BP monitoring. -Resident #2's monthly BP checks were not on the MAR, so she did not know to obtain Resident #2's BP. Interview with Resident #2 on 11/22/22 at 3:47pm revealed: -She had her BP monitored once or twice a week. -She thought that she did not have hypertension. Attempted telephone interview with Resident #2's PCP's office on 11/22/22 at 1:56pm. Refer to the interview with the RCC on 11/22/22 at 2:57pm. Refer to the telephone interview with the Administrator on 11/22/22 at 4:15pm. _____ Interview with the RCC on 11/22/22 at 2:57pm revealed: -She and the Administrator reviewed residents' FL-2s. -She knew Residents #1 and #2 had monthly BP monitoring ordered by the PCP. -She did not know the BP monitoring was not entered onto residents' MARs. -She told staff to do residents' BPs monthly. -She visited the facility weekly. -She did not know of another place where staff might have documented residents' BPs checks. Telephone interview with the Administrator on 11/22/22 at 4:15pm revealed:	C 249		

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C 249	Continued From page 6 -She expected staff to obtain BP's as ordered by the PCP. -She expected the pharmacy to place BP monitoring on the MAR. -She did not review any residents' FL-2s after the PCP signed them. -Staff were responsible for ensuring residents' blood pressures were checked as ordered and documented.	C 249		
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, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 2 of 3 sampled residents (#1 and #3) related to a inhalant used to control symptoms of chronic obstructive pulmonary disease (COPD), a mineral supplement used for vitamin D deficiency (#1), and a discontinued medication used to control the symptoms of seasonal allergies that was administered (#3). The findings are: 1. Review of Resident #1's current FL-2 dated	C 330		

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04/21/22 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, hyperlipidemia, depression, and schizophrenia.

a. Review of Resident #1's current FL-2 dated 04/21/22 revealed there was a medication order for ipratropium (used to treat bronchospasms with COPD) 0.02% solution 0.5mg/albuterol 2.5mg/0.5ml nebulizers inhale 0.5ml into lungs as needed every 6 hours.

Review of Resident #1's Primary Care Provider (PCP) orders dated 10/26/22 revealed there was an order for ipratropium bromide 0.02% solution take 2.5ml nebulizer four times daily.

Review of Resident #1's September 2022 printed medication administration record (MAR) revealed:
-There was a missing page of the September 2022 MAR (page 2 of 2).
-There was no documentation of administration on page 1 of the September 2022 MAR of ipratropium-albuterol solution.

Review of Resident #1's October 2022 printed MAR revealed:
-There was an entry for ipratropium-albuterol 0.5-0.3mg (2.5)/3ml inhale contents of one vial into lung every six hours as needed.
-There was documentation of administration of ipratropium-albuterol nebulizer on 10/01/22, 10/06/22, and twice daily from 10/11/22 to 10/24/22.
-There was no entry for scheduled ipratropium bromide 0.02% solution nebulizers.

Review of Resident #1's November 2022 printed MAR revealed:
-There was an entry for ipratropium-albuterol

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C 330	Continued From page 8 0.5-0.3mg (2.5)/3ml inhale contents of one vial into lung every six hours as needed. -There was documentation of administration of ipratropium-albuterol nebulizer on 11/01/22, 11/04/22, 11/06/22, and daily from 11/08/22 to 11/15/22 and 11/17/22 to 11/21/22. -There was no entry for scheduled ipratropium bromide 0.02% solution nebulizers. Observation of Resident #1 on 11/22/22 at 12:47pm revealed: -There was one box of ipratropium bromide solution vial which contained 30 vials of solution. -The ipratropium was dispensed on 10/26/22. Review of Resident #1's ipratropium bromide solution pharmacy label revealed: -The written date for the ipratropium nebulizer order was 10/26/22 and filled on 10/26/22. -The instructions for administration were take 2.5ml by nebulizer four times daily. Interview with Resident #1 on 11/22/22 at 3:53pm revealed she used an inhaler daily and nebulizers 2 to 3 times per week. Telephone interview with a pharmacist at Resident #1's facility contracted pharmacy on 11/22/22 at 1:48pm revealed: -There was an order dated 04/21/22 on Resident #1's FL-2 for Duoneb inhale contents of one vial into lung every six hours as needed. -There was a recent order sent electronically dated 10/26/22 for ipratropium bromide 0.02% solution take 2.5ml by nebulizer four times daily. -Thirty vials of ipratropium bromide solution nebulizer were dispensed on 10/26/22 and 11/06/22. -Resident #1's order for ipratropium bromide was received after the November 2022 MARs were	C 330		

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sent to the facility.
-The facility would be responsible for either entering the ipratropium bromide onto the November 2022 MAR or requesting a new MAR with the new order for ipratropium bromide.

Interview with a MA on 11/22/22 at 2:20pm revealed:
-She reviewed the new MARs when the pharmacy delivered them at the end of the previous month.
-She used the previous months MARs and the delivered cycle fill medications to check the new MARs.
-If there was a delivered medication that did not appear on the new MARs she notified the pharmacy.
-She did not place a medication on the MARs until the medication was in the facility.
-She did not know Resident #1's ipratropium nebulizer order was changed on 10/26/22.
-She did not take Resident #1 to the appointment on 10/26/22.
-She did not administer nebulizers to Resident #1 unless Resident #1 was short of breath.
-She did not administer nebulizers to Resident #1 four times daily.

Interview with the Resident Care Coordinator (RCC) on 11/22/22 at 2:57pm
-She took Resident #1 to her medical appointment on 10/26/22.
-She remembered Resident #1's Primary Care Provider (PCP) discussing medications.
-She received the paperwork from Resident #1's PCP but she did not change the entry for ipratropium on the MARs.
-This was her mistake and she did not catch the mistake.

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Telephone interview with the Administrator on 11/22/22 at 4:45pm revealed:
-She did not know Resident #1's ipratropium was changed to scheduled four times daily.
-Staff who took Resident #1 to her appointment was expected to review the paperwork and change the entry of ipratropium on the MARs.

Attempted telephone interview with Resident #1's PCP on 11/22/22 at 1:56pm was unsuccessful.

Refer to the telephone interview with the Administrator on 11/22/22 at 4:45pm.

b. Review of Resident #1's Primary Care Provider (PCP) orders dated 05/31/22 revealed there was a medication order for vitamin D (used to treat vitamin D deficiency) 50mcg (2000 units) capsules one capsule daily.

Review of Resident #1's September 2022 printed medication administration record (MAR) revealed:
-There was an entry for vitamin D3 2000 units take one capsule daily, scheduled for 8:00am.
-There was no documentation of administration of vitamin D3 for the entire month of September 2022.

Review of Resident #1's October 2022 printed MAR revealed:
-There was an entry for vitamin D3 2000 units take one capsule daily, scheduled for 8:00am.
-Vitamin D3 was documented as administered from 10/01/22 to 10/31/22.

Review of Resident #1's printed MAR 11/01/22-11/22/22 revealed:
-There was an entry for vitamin D3 2000 units take one capsule daily, scheduled for 8:00am.
-Vitamin D3 was documented as administered

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C 330	Continued From page 11 from 11/01/22 to 11/22/22. Observation of Resident #1 on 11/22/22 at 12:47pm revealed: -There was one over the counter bottle of vitamin D3 2000 units capsules. -The majority of the 250 capsules were not in the bottle. -The bottle of vitamin D3 was not labeled with any residents' name. Interview with Resident #1 on 11/22/22 at 3:53pm revealed she did not know if she took vitamin D3 or not and she did not remember her PCP discussing vitamin D3. Telephone interview with a pharmacist at Resident #1's facility contracted pharmacy on 11/22/22 at 1:48pm revealed: -There was an order dated 05/31/22 for Resident #1 for vitamin D3 2000 units one capsule daily. -Resident #1's vitamin D3 was on hold and not dispensed to the facility. -All of Resident #1's over the counter medication was placed on hold. -The reason for the hold was probably because the Administrator planned to purchase the vitamin D3. Interview with a MA on 11/22/22 at 2:20pm revealed: -She did not know Resident #1's vitamin D3 was not entered onto the September 2022 MAR. -The only vitamin D3 that was available for administration was a bottle for house stock. -There was more than one resident with vitamin D3 ordered. -She did not know a reason for why vitamin D3 was not on Resident #1's September 2022 MAR. -She did not recall notifying the pharmacy	C 330		

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concerning Resident #1's vitamin D3.
-She thought the Resident Care Coordinator (RCC) or the Administrator purchased vitamin D3 for residents.
-She might have purchased the house stock of vitamin D3 but she could not remember.

Interview with the Resident Care Coordinator (RCC) on 11/22/22 at 2:57pm
-She did not know Resident #1's September 2022 MAR did not have an entry for vitamin D3.
-She thought Resident #1 received vitamin D3 as ordered because she purchased a bottle of vitamin D3.
-She did not have the receipt for the purchase of vitamin D3 and she did not know when she purchased the vitamin D3.
-She saw that the house stock bottle of vitamin D3 did not have a resident's name written on it.
-She knew that if there was no documentation of the administration, then it was not administered.

Telephone interview with the Administrator on 11/22/22 at 4:45pm revealed:
-She did not know Resident #1's vitamin D3 was not entered on the September 2022 MARs.
-Staff and the pharmacy did not detect the error.
-The staff who worked at the end of August 2022 and reviewed the new MARs for September 2022 was responsible for not entering Resident #1's vitamin D3 on the MAR.

Attempted telephone interview with Resident #1's PCP on 11/22/22 at 1:56pm was unsuccessful.

Refer to the telephone interview with the Administrator on 11/22/22 at 4:45pm.

2. Review of Resident #3's current FL-2 dated 04/05/22 revealed:

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C 330	Continued From page 13 -Diagnoses included cannabis use disorder, sustain remission, cocaine use disorder sustain remission and schizophrenia. -There was a medication order for diphenhydramine (used to relieve the symptoms related to allergies and the common cold) 25mg capsule take 2 capsules as needed for sleep. Review of Resident #3's Primary Care Provider (PCP) orders dated 05/25/22 revealed there was an order to discontinue diphenhydramine 25mg take two tablets daily as needed for sleep. Review of Resident #3's September 2022 printed medication administration record (MAR) revealed: -There was an entry for diphenhydramine 25mg caplet take two tablets at bedtime as needed for sleep. -There was no documentation of administration of diphenhydramine. Review of Resident #3's October 2022 printed MAR revealed: -There was an entry for diphenhydramine 25mg caplet take two tablets at bedtime as needed for sleep. -There was documentation of administration of diphenhydramine on 10/01/22 at 7:00am, 10/02/22 at 7:00pm, and 10/22/22 at 2:00pm. Review of Resident #3's November 2022 printed MAR revealed: -There was an entry for diphenhydramine 25mg caplet take two tablets at bedtime as needed for sleep. -There was documentation of administration of diphenhydramine on 11/03/22 at 7:00pm, 11/07/22 at 7:00pm, 11/10/22 at 7:00pm and 11/13/22 at 7:00am.	C 330		

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	FCL035028	A. BUILDING: _____ B. WING _____	11/22/2022

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C 330	Continued From page 14 Observation of Resident #3 on 11/22/22 at 12:47pm revealed: -There was one opened over the counter bottle of diphenhydramine caplets. -Resident #3's name was written on the bottle cap, but there was no opened date on the bottle. -The bottle had 365 caplets of diphenhydramine when unopened. Interview with Resident #3 on 11/22/22 at 3:50pm revealed: -He took diphenhydramine once every 2 weeks for cough and the common cold. -He requested diphenhydramine from his Primary Care Provider (PCP) because he knew he might catch a cold. Telephone interview with a representative at the facility contracted pharmacy on 11/22/22 at 1:58pm revealed: -Resident #3's diphenhydramine was an active order and the last order date was 04/05/22 the date of Resident #3's FL-2. -The pharmacy did not receive any discontinue order for Resident #3's diphenhydramine. Interview with a MA on 11/22/22 at 2:20pm revealed: -When a medication was discontinued, she highlighted it on the MAR and documented discontinued, her initials and the date. -She did not know Resident #3's diphenhydramine was discontinued in May 2022. -She had administered diphenhydramine to Resident #3. -If she had known Resident #3's diphenhydramine was discontinued she would not have administered it to him. Interview with the Resident Care Coordinator	C 330		

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C 330	Continued From page 15 (RCC) on 11/22/22 at 2:57pm -SICs were supposed to fax orders to the pharmacy and leave the orders for her to review. -She expected the SICs to tell her when she visited the facility about any PCP orders. -When she was aware of PCP orders, she reviewed the orders for accuracy. -She did not know there was an order to discontinue Resident #3's diphenhydramine. -She expected the SICs to document on the MAR when a medication was discontinued. Telephone interview with the Administrator on 11/22/22 at 4:45pm revealed: -She expected the SICs to fax discontinue orders to the pharmacy and the pharmacy would remove it from the resident's list of orders. -She expected the SICs to remove the discontinued medication from the resident's MAR. -The SICs should make the RCC and the Administrator aware of any new orders. Attempted telephone interview with Resident #2's PCP on 11/22/22 at 1:56pm was unsuccessful. Refer to the telephone interview with the Administrator on 11/22/22 at 4:45pm. _____ Telephone interview with the Administrator on 11/22/22 at 4:45pm revealed she held the staff who administered medications responsible for administering medications as ordered.	C 330		
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.	C935		

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C935	Continued From page 16 (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: Based on interviews and record reviews, the	C935		

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C935	Continued From page 17	C935		

facility failed to assure 1 of 2 sampled medication aides (Staff B) completed the 5, 10, 15-hour state approved medication administration training course as required and had taken and passed the medication aide (MA) test within 60 days of completing the medication clinical skill competency validation checklist.

The findings are:

Review of Staff B's personal care aide (PCA) personnel record revealed:
-She was hired to work on 09/16/21.
-There was no documentation Staff B had passed the medication aide test.
-There was documentation of Staff B's medication clinical skill competency validation checklist.
-There was no documentation Staff B had completed a 5-hour training program and an additional 10-hour training program within 60 days of hire.

Review of the residents' printed Medication Administration Records (MARs) for September 2022 revealed Staff B administered medications on 09/01/22-09/13/22 and 09/28/22-09/30/22.

Review of the residents' MARs for October 2022 revealed Staff B administered medications on 10/01/22-10/10/22 and 10/26/22-10/31/22.

Review of residents' MARs for November 2022 revealed Staff B administered medications on 11/01/22-11/08/22.

Telephone interview with Staff B on 11/22/22 at 1:41pm revealed:
-She was hired by the Administrator in 2021.
-She has worked as a PCA since 2009.

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C935	Continued From page 18 -She had administered medications since September 2021. -She had not taken the medication aide (MA) test or completed a 5-hour training program or an additional 10-hour training program within 60 days of hire. -The Administrator had arranged MA training for her online and she planned to take the MA test soon. -She attempted to take the MA test previously but she did not have the proper identification. Telephone interview with the Administrator on 11/22/22 at 4:15pm revealed: -Staff B had not taken the MA test. -She thought Staff B had completed the 15-hour medication aide training. -Staff B worked at another type of facility, but due to staffing shortages she came to work at the family care home. -She thought Staff B had attempted to take the medication aide test, but she did not have the required identification. -She was responsible for making sure Staff B was qualified to administered medications. -She was responsible for auditing staff qualifications, but she did not know the last time she reviewed the staff qualifications.	C935		