STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032096	A. BUILDING: _____ B. WING _____	R 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES FAMILY HOME	2122 OVERLAND DRIVE DURHAM, NC 27704

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C 000	Initial Comments The Adult Care Licensure Section and the Durham County Department of Social Services conducted an annual and follow-up survey on April 11, 2023.	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 2 sampled staff (A) had documentation they were tested for Tuberculosis (TB) disease upon hire according to control measures for the Commission for Public Health. The findings are: Review of Staff A's personnel record revealed: -There was no hire date documented. -There was a job description for a medication aide (MA) dated 02/12/23. -There was no documentation of a TB skin test completed prior to or since being employed by the	C 140		

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C 140	Continued From page 1 facility. Interview with Staff A on 04/11/23 at 4:25pm revealed: -She was hired in February 2023 but did not remember the exact date. -She worked as a MA. -She received her first step and second step TB skin tests in February 2023 and March 2023, but could not remember the exact dates. -The House Manager took her to the physician's office to have the TB test administered and read. -She did not remember receiving a paper with the results of her TB test. Interview with the House Manager on 04/11/23 at 4:31pm revealed: -Staff A was hired as a MA in February 2023. -She transported Staff A to the physician's office to have the TB skin test administered and read. -She had transported Staff A to the physician's office to have the first and second TB tests administered and read. -She received the TB test results. -She thought she placed them in Staff A's personnel record. Telephone interview with the Director on 04/11/23 at 4:34 pm revealed: -Staff A should have had a TB test completed. -He thought she had the TB test completed at the physician's office. -He did not know the results from Staff A's TB test were not in Staff A's personnel record. -It was the responsibility of the Director and the Assistant Director to ensure all personnel records were complete.	C 140		

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C 145	Continued From page 2	C 145		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 2 staff sample (A) had no substantiated findings on the North Carolina Health Care Personnel Registry prior to hire at the facility. The findings are: Review of Staff A's personnel record revealed: -There was no hire date documented. -There was a job description for a medication aide (MA) dated 02/12/23. -There was no documentation that a Health Care Personnel Registry (HCPR) check was completed Observation on 04/11/23 between 8:15am and 4:30pm revealed: -Staff A worked as a MA. -Staff A provided personal care, administered medications, and cooked and served meals to the residents. Interview with Staff A on 04/11/23 at 2:50pm revealed: -She had worked at this facility since February 2023; she could not remember the exact date. -She provided personal care, administered medications, and prepared and served meals to	C 145		

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C 145	Continued From page 3 the residents. -She did not know what an HCPR was and did not know who was responsible for checking the HCPR. Interview with the House Manager on 04/11/23 at 4:31pm revealed: -She thought the Director or Assistant Director was responsible for checking the HCPR. -The Director would check the HCPR and bring the completed HCPR to the facility. -She was responsible for filing the HCPR in Staff A's personnel record. -She did not remember receiving Staff As completed HCPR or filing in Staff A's personnel record. Interview with the Director on 04/11/23 at 4:34pm revealed: -He was responsible for checking the HCPR with each new hire. -The Assistant Director would sometimes check the HCPR -He was certain that he or the Assistant Director checked Staff A's HCPR. -He thought Staff A's HCPR had been checked and filed in Staff A's personnel record. On 04/12/23, the facility provided Staff A's HCPR check dated 04/12/2023, with no substantiated findings.	C 145		
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 completed	C 147		

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C 147	Continued From page 4 in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 2 staff sampled (A) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -There was no hire date documented. -There was a job description for a medication aide (MA) dated 02/12/23. -There was no documentation that a Health Care Personnel Registry (HCPR) check was completed -There was no criminal background check documented and available for review. Observation on 04/11/23 from 8:15am - 4:30pm revealed: -Staff A worked as the MA. -Staff A provided personal care, administered medications, and cooked and served meals to the residents. Interview with Staff A on 04/11/23 at 2:50 pm revealed: -She had worked at the facility since February 2023; she could not remember the exact date. -She provided personal care, administered medications, and cooked and served meals to the residents. -She did not know if a criminal background check had been completed. -She did not recall signing a release form to have her criminal background checked.	C 147		

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C 147	Continued From page 5 Interview with the House Manager on 04/11/23 at 4:31 revealed: -She thought the Director, or the Assistant Director was responsible for the criminal background check. -When the criminal background check was completed, the Director brought the forms to her so she could file in Staff A's personnel record. -She did not remember if she had received a criminal background check to file in Staff A's personnel file. Telephone interview with the Director on 04/11/23 at 4:37pm revealed: -The Assistant Director was responsible for checking the criminal background check on all new employees. -He thought the Assistant Director had completed the criminal background check on Staff A. -He expected the criminal background check to be completed on all new employees before starting work. -The facility provided a signed release form for Staff A dated 04/12/23 to have her criminal background check completed.	C 147		
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 orders specified in Subparagraph (c)(3) of this Rule.	C 249		

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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 2 of 2 sampled residents (#1, #3) with orders for finger stick blood sugar (FSBS) checks three times weekly (#1); and daily blood pressure (BP) checks (#3).

The findings are:

1. Review of Resident #1's current FL-2 dated 05/16/22 revealed diagnoses included diabetes mellitus type II, hyperlipidemia, schizophrenia, and hypertension.

Review of Resident #1's signed physician's orders dated 05/16/22 revealed an order for fingerstick blood sugar checks (FSBS) three times daily.

Review of Resident #1's Licensed Health Professional Support (LHPS) tasks dated 04/22/21 revealed:
-Resident #1 was ordered FSBS checks.
-There was no frequency for FSBS checks listed.

Review of Resident #1's February 2023, March 2023, and April 2023 medication administration record (MAR) revealed there was no entry for FSBS checks three times daily.

Review of Resident #1's FSBS log on 04/11/23 revealed:
-Resident #1's FSBS was checked twice a day from 03/01/23 to 03/15/23 and 03/27/23 to 03/31/23.
-There were no FSBS readings documented from 03/16/23 to 03/26/23.

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C 249	Continued From page 7 -Resident #1's FSBS was checked 40 times in March 2023. -Resident #1's FSBS was checked twice a day from 04/01/23 to 04/08/23. -There were no FSBS readings documented from 04/09/23 to 04/11/23. -Resident #1's FSBS was checked 16 times in April 2023. Observation of Resident #1's glucometer on 04/11/23 at 4:15PM revealed: -There were three readings on 04/09/23 of 98, 138, 175. -There was one reading on 04/10/23 of 159. -There was one reading on 04/09/23 of 131. Interview with Resident #1 on 04/11/23 at 8:45am revealed: -He checked his own FSBS reading daily. -He would tell the medication aide (MA) what his FSBS reading was each day. -He did not know he had an order to check his FSBS reading three times daily. -He did not think his FSBS needed to be checked three times a day. -He checked his FSBS this morning, 04/11/23. -He did not recall what his FSBS reading was this morning. Interview with the MA on 04/11/23 at 2:58pm revealed: -Resident #1 checked his FSBS and reported the FSBS reading to the MA. -Resident #1 checked his FSBS every day; he would check it more often if he did not feel well. -She did not know Resident #1 had an order for FSBS checks three times a day. -There was no entry on the MAR to check Resident #1's FSBS.	C 249		

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C 249	Continued From page 8 Interview with the House Manager on 04/11/23 at 11:51am revealed: -Resident #1 checked his FSBS daily. -Resident #1's glucometer and supplies were kept with the medications. -She did not know Resident #1 had an order to check his FSBS three times a day. Interview with the Director on 04/11/23 at 4:39pm revealed: -He could not recall what the FSBS order was for Resident #1. -He did not know Resident #1 had an order for FSBS checks three times a day. -The MA was expected to check his FSBS three times a day and record the FSBS readings. Attempted telephone interview with Resident #1's PCP (Primary Care Provider) on 04/11/23 at 4:05pm was unsuccessful. 2. Review of Resident #3's current FL-2 dated 10/20/22 revealed diagnosis included paranoid schizophrenia. Review of Resident #3's signed physicians order dated 01/10/23 revealed an order to check blood pressure (BP) reading daily and call the Primary Care Provider (PCP) if BP greater than 140/80. Review of Resident #3's February 2023 medication administration record (MAR) revealed: -There was an entry for BP checks three times a week and record findings. -There was documentation Resident #3's BP reading was obtained 13 times out of 28 days. -The BP readings were not documented on the MAR. Review of Resident #3's March 2023 MAR	C 249		

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revealed:
-There was an entry for BP checks three times a week and record readings.
-There was documentation Resident #3's BP reading was obtained 5 times out of 31 days.
-The BP readings were not documented on the MAR.

Review of Resident #3's April 2023 MAR from 04/01/23 to 04/11/23 revealed:
-There was an entry for BP checks three times a week and record readings.
-There was no documentation the Resident #3's BP had been obtained from 04/01/23 to 04/11/23.
-The BP readings were not documented on the MAR.

Review of Resident #3'S BP from on 04/11/23 revealed:
-Resident #3's BP reading was recorded 23 times from 01/03/23 to 02/28/23.
-Resident #3's BP readings ranged from 121/70 to 142/74.
-Resident #3 had no BP readings recorded between 03/01/23 to 04/11/23.

Interview with Resident #3 on 04/11/23 at 8:25am revealed:
-He had high blood pressure.
-He took medications for his blood pressure.
-The medication aide (MA) used to check his BP, but it has not been checked in 6 weeks.
-He did not know why his BP was not checked for 6 weeks.

Interview with the medication aide on 04/11/23 at 2:53pm revealed:
-She had not checked Resident #3's BP.
-The BP cuff in the facility was too big for Resident #3.

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-She thought the Director had ordered a new BP machine for Resident #3.
-She knew there was an entry on the MAR to check Resident #3's BP three times a week.
-She did not know there was a new order to check Resident #3's BP daily.

Interview with the House Manager on 04/11/23 at 11:51am revealed:
-She knew there was an entry on Resident #3's MARS to check BP three times a week.
-She did not recall seeing an order for Resident #3's BP to be checked daily and to notify the PCP if BP was greater than 140/80.
-She was responsible for reviewing new orders and ensuring they were implemented.
-She had checked Resident #3's BP and recorded the BP reading on the BP form.
-She did not know there was no BP cuff available to check Resident #3's BP.

Interview with the Director on 04/11/23 at 4:39pm revealed:
-He knew Resident #3 had an order for daily BPs.
-He did not know the entry on the MAR was for three times a week.
-He did not know there were no BP readings for Resident #3 since 02/28/23.
-He thought there was a BP cuff in the facility to check Resident #3's BP.
-He had not been notified that a BP cuff was needed to check Resident #3's BP.
-He did not know why Resident #3's BP checks were not conducted daily as ordered.
-He expected the staff to take the BP checks as ordered and to document the results.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 04/11/23 at 4:05pm was unsuccessful.

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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 the physician for 3 of 3 sampled residents (#1, #2, and #3) related to an antidepressant (#1), a nasal spray, an inhaler, and a medication for anxiety (#2), and a supplement (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 05/16/22 revealed -Diagnosis included schizophrenia. -He was constantly disoriented. -There was an order for mirtazapine (used to treat depression and anxiety) 15mg at night. Review of Resident #1's signed physician order dated 12/29/22 revealed an order to increase mirtazapine 15mg one and one-half tablets at night. Review of Resident #1's February 2023 medication administration record (MAR) revealed: -There was an entry for mirtazapine OTD 15mg	C 330		

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1.5 tablets at bedtime with a scheduled administration time of 8:00pm.
-There was documentation mirtazapine OTD 15mg 1.5 tablets were administered from 02/01/23 to 02/28/23 at 8:00pm.

Review of Resident #1's March 2023 MAR revealed:
-There was an entry for mirtazapine OTD 15mg 1.5 tablets at bedtime with a scheduled administration time of 8:00pm.
-There was documentation mirtazapine OTD 15mg 1.5 tablets were administered from 03/01/23 to 03/31/23 at 8:00pm.

Review of Resident #1 April 2023 MAR from 04/01/23 to 04/10/23 revealed:
-There was an entry for mirtazapine OTD 15mg 1.5 tablets at bedtime with a scheduled administration time of 8:00pm.
-There was documentation mirtazapine OTD 15mg 1.5 tablets were administered from 04/01/23 to 04/03/23 and 04/05/23 to 04/10/23 at 8:00pm.

Observation of Resident #1's medications on hand on 04/11/23 at 10:46am revealed there was no mirtazapine OTD available to administer to Resident #1.

Interview with Resident #1 on 04/11/23 at 8:20am revealed he took medications at night before going to bed, but he was not sure how many medications he took or what they were for.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/11/23 at 1:57pm revealed:
-Resident #1 had an order for mirtazapine OTD 15mg 1 ½ tablets at bedtime dated 12/29/22.

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-The pharmacy dispensed 45 tablets mirtazapine 15mg on 12/29/22, 01/31/23, and 02/28/23.
-The forty-five tablets were dispensed in a blister pack with each blister containing 1.5 tablets.
-One blister pack of 45 tablets would last Resident #1 30 days.
-The pharmacy was not able to dispense mirtazapine OTD in the multi-dose pack.
-The pharmacy did not dispense mirtazapine in March 2023 because the prescription did not have any refills.
-The pharmacy sent a request to the physician for a prescription to fill mirtazapine 15mg OTD, but the pharmacy did not receive authorization.
-The facility did not notify the pharmacy to request or inquire about the medication.

Interview with the medication aide (MA) on 04/11/23 at 2:53pm revealed:
-She did not administer mirtazapine to Resident #1 because it was not in the multi-dose pack.
-She thought all of Resident #1's pills were dispensed in the multi-dose pack.
-She did not know to look for a blister pack containing mirtazapine 15mg 1 ½ tablets at night.
-She signed the MAR by accident, thinking she had been administering mirtazapine when she had not.

Interview with the House Manager on 04/11/23 at 12:08pm and 4:15pm revealed:
-Mirtazapine was in the multi-dose pack with Resident #1's other medications.
-She administered Resident #1's mirtazapine each night with the other bedtime medications.
-She thought Resident #1's mirtazapine was in the multi-dose pack with the other medications.
-She documented she administered mirtazapine because she thought she administered the medication.

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JONES FAMILY HOME	2122 OVERLAND DRIVE DURHAM, NC 27704

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-She did not know the pharmacy had not dispensed mirtazapine since 2/28/23.
-She did not know there were no refills remaining for mirtazapine to be re-filled.
-She had not called the pharmacy because she did not realize the medication was not in the facility.

Attempted interview with Resident #1's Primary Care Provider on 04/01/23 a 4:03pm was unsuccessful.

Refer to the interview with the House Manager on 04/11/23 at 4:15pm.

Refer to the telephone interview with the Director on 04/11/23 at 4:39pm.

2. Review of Resident #2's current FL-2 dated 01/30/23 revealed diagnoses included paranoid schizophrenia, Parkinson's disease, chronic pulmonary obstructive disease.

a. Review of Resident #2's current FL-2 dated 01/30/23 revealed there was an order for clonazepam (used to treat anxiety) 0.5mg three times daily.

Review of Resident #2's February 2023 medication administration record (MAR) revealed:
-There was an entry for clonazepam 0.5mg three times daily with an administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation clonazepam was administered three times daily from 02/01/23 to 02/28/23 at 8:00pm.

Review of Resident #2's March 2023 MAR revealed:
-There was an entry for clonazepam 0.5mg three

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times daily with an administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation clonazepam was administered three times daily from 03/01/23 to 03/31/23 at 8:00pm.

Review of Resident #2's April 2023 MAR from 04/01/23 to 04/10/23 revealed:
-There was an entry for clonazepam 0.5mg three times daily with an administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation clonazepam was administered three times daily from 04/01/23 to 04/08/23 and 04/09/23 at 2:00pm and 8:00pm.

Observation of Resident #2's medications on hand on 04/11/23 at 10:46am revealed:
-There were three bubble packs of 30 clonazepam 0.5mg tablets available for administration.
-There were 90 or 90 clonazepam remaining for administration.
-The dispensed date on the prescription label was 03/28/23.

Interview with Resident #2 on 04/11/23 at 3:35pm revealed:
-He knew she took several medications a day but did not know the names of the medications.
-He was administered medications during the day and at night but could not recall if he received his medication for anxiety.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/11/23 at 1:57pm revealed:
-The pharmacy had an order for clonazepam 0.5mg three times daily.
-The pharmacy dispensed 90 clonazepam 0.5mg tablets for Resident #2 on 03/28/23.

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-The medication should have been in the facility for administration on 03/29/23.
-Clonazepam was used for anxiety.

Interview with the medication aide (MA) on 04/11/23 at 2:53pm revealed:
-She administered clonazepam to Resident #2 three times a day.
-She documented on the MAR she administered the medication.
-She would not document she administered the medication if she did not administer the medication.
-She did not realize that the clonazepam that was dispensed on 03/28/23 had not been administered.
-She thought she administered Resident #2's his clonazepam as ordered.

Interview with the House Manager on 04/11/23 at 12:08pm and 4:15pm revealed:
-She administered Resident #2's clonazepam as ordered and documented on the MAR.
-She did not know the Resident #2 had 90 clonazepam dispensed on 03/28/23, and 90 tablets were still available for administration.
-She did not audit the medications for the Resident; the Director did medication audits.
-She needed to be careful when administering medications and make sure she administered medications as ordered.

Attempted interview with Resident #2's Primary Care Provider on 04/01/23 a 4:03pm was unsuccessful.

Refer to the interview with the House Manager on 04/11/23 at 4:15pm.

Refer to the telephone interview with the Director

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C 330	Continued From page 17 on 04/11/23 at 4:39pm. b. Review of Resident #2's current FL-2 dated 01/30/23 revealed there was an order for Advair (used to treat depression and anxiety) 250/50 diskus one inhalation every 12 hours. Review of Resident #1's February 2023 medication administration record (MAR) revealed: -There was an entry for Advair 250/50 Diskus 1 inhalation every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Advair was administered twice daily from 02/01/23 to 02/28/23. Review of Resident #1's March 2023 MAR revealed: -There was an entry for Advair 250/50 Diskus 1 inhalation every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Advair was administered twice daily from 03/01/23 to 03/31/23. Review of Resident #1 April 2023 MAR from 04/01/23 to 04/10/23 revealed: -There was an entry for Advair 250/50 Diskus 1 inhalation every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Advair was administered twice daily from 04/01/23 to 04/10/23 and on 04/11/23 at 8:00am. Observation of Resident #2's medications on hand on 04/11/23 at 10:46am revealed: -There was one Advair 250/50 Diskus 50 of 60 inhalations available for administration. -The Advair Diskus was dispensed on 01/31/23. -There was a second Advair 205/50 Diskus	C 330		

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dispensed on 02/28/23.
-The second Advair Discus was unopened and remained sealed in its container.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/11/23 at 1:57am revealed:
-The pharmacy had an order for Advair 250/50 Diskus one inhalation every 12 hours.
-The pharmacy dispensed one Advair Diskus on 01/03/23, 01/31/23, and 02/28/23.
-One Advair Diskus contained 60 inhalations and would last 30 days when ordered every 12 hours.

Interview with Resident #2 on 04/11/23 at 4:09pm revealed:
-He did not receive Advair inhaler daily.
-He did not know the last time he used Advair inhaler.
-He did not have any complaints of shortness of breath.

Interview with the medication aide (MA) on 04/11/23 at 2:53pm revealed:
-She administered Resident #2 his Advair Diskus as ordered.
-She did not know why there was more on hand than there should be.

Interview with the House Manager on 04/11/23 at 12:08pm revealed:
-The pharmacy dispensed inhalers monthly with the oral medications.
-The facility staff did not have to notify the pharmacy for refills for inhalers.
-She thought the pharmacy dispensed inhalers with the monthly oral medications.
-She did not know the facility staff had to notify the pharmacy to refill inhalers.
-She administered Resident #2 his inhaler as

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ordered.
-She did not know only 10 inhalations had been administered from the inhaler dispensed on 01/31/23 and the inhaler dispensed on 02/28/23 had not been opened.

Attempted interview with Resident #2's Primary Care Provider on 04/01/23 a 4:03pm was unsuccessful.

Refer to the interview with the House Manager on 04/11/23 at 4:15pm.

Refer to the telephone interview with the Director on 04/11/23 at 4:39pm.

c. Review of Resident #2's current FL-2 dated 01/30/23 revealed there was an order for fluticasone (used to treat runny nose, itchy eyes, and sneezing related to allergies) 50mcg 2 sprays each nostril every morning.

Review of Resident #2's February 2023 medication administration record (MAR) revealed:
-There was an entry for fluticasone nasal spray 2 sprays into each nostril daily with a scheduled administration time of 8:00am.
-There was documentation fluticasone nasal spray was administered daily from 02/01/23 to 02/28/23.

Review of Resident #2's March 2023 MAR revealed:
-There was an entry for fluticasone nasal spray 2 sprays into each nostril daily with a scheduled administration time of 8:00am.
-There was documentation fluticasone nasal spray was administered daily from 03/01/23 to 03/31/23.

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C 330	Continued From page 20 Review of Resident #2 April 2023 MAR from 04/01/23 to 04/10/23 revealed: -There was an entry for fluticasone nasal spray 2 sprays into each nostril daily with a scheduled administration time of 8:00am. -There was documentation fluticasone nasal spray was administered daily from 04/01/23 to 04/11/23. Observation of medication on hand on 04/11/23 at 11:04pm revealed: -There was an opened bottle, ½ full, of fluticasone nasal spray with a dispensed date of 12/06/22. -There were two bottles of unopened fluticasone nasal spray dispensed on 01/31/23 and 02/28/23. Interview with Resident #2 on 04/11/23 at 4:09pm revealed: -He did not remember receiving his nasal spray this morning. -He thought he received the nasal spray yesterday morning. -He was not administered his fluticasone nasal spray daily. -He was administered fluticasone nasal spray when needed for allergies. -He was not having any problems with itchy eyes, running nose, or sneezing today. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 04/11/23 at 1:57pm revealed: -The pharmacy had an order for fluticasone nasal spray 2 sprays into each nostril daily. -The pharmacy dispensed one bottle of fluticasone nasal spray on 11/17/22, 01/31/23, and 02/28/23. -One bottle of fluticasone nasal spray contained 120 nasal sprays.	C 330		

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C 330	Continued From page 21 -The bottle of fluticasone nasal spray would last 30 days when administered 2 sprays into each nostril daily. Interview with the medication aide (MA) on 04/11/23 at 2:53pm revealed: -She administered Resident #2 his fluticasone nasal spray as ordered. -She did not know why there was more fluticasone nasal spray on hand than there should be. Interview with the House Manager on 04/11/23 at 12:08pm revealed: -The pharmacy dispensed nasal sprays monthly with the oral medications. -She administered Resident #2's nasal spray as ordered. -She had not noticed the bottle of fluticasone being used for Resident #2 was dispensed on 12/06/22. -She did not know why the facility staff was using fluticasone nasal spray that was dispensed on 12/06/22. -She did not know why Resident #2 still had an unopened bottle of fluticasone nasal spray still available for administration from 02/28/23. -The staff may not be administering the nasal spray correctly. Attempted interview with Resident #2's Primary Care Provider on 04/01/23 a 4:03pm was unsuccessful. Refer to the interview with the House Manager on 04/11/23 at 4:15pm. Refer to the telephone interview with the Director on 04/11/23 at 4:39pm.	C 330		

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3. Review of Resident #3's current FL-2 dated 10/20/22 revealed:
-Diagnoses included paranoid schizophrenia
-There was an order for vitamin D3 (used as a supplement)1000 units daily.

Review of Resident #3's February 2023 medication administration record (MAR) reveal:
-There was an entry for vitamin D3 1000units daily with a scheduled administration time of 8:00am.
-There was documentation vitamin D3 was administered daily from 02/01/23 to 02/28/23.

Review of Resident #3's March 2023 MAR revealed:
-There was an entry for vitamin D3 1000units daily with a scheduled administration time of 8:00am.
-There was documentation vitamin D3 was administered daily from 03/01/23 to 03/31/23.

Review of Resident #3's April 2023 MAR from 04/01/23 to 04/11/23 revealed:
-There was an entry for vitamin D3 1000units daily with a scheduled administration time of 8:00am.
-There was documentation vitamin D3 was administered daily from 04/01/23 to 04/11/23.

Observation of Resident #3's medications on hand on 04/11/23 at 11:15am revealed there was no vitamin D3 1000 units to be administered.

Interview with the medication aide (MA) on 04/11/23 at 2:58pm revealed:
-She remembered administering Resident #3 his vitamin D3.
-She did not remember the last time she administered vitamin D3 to Resident #3.

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C 330	Continued From page 23 Interview with the House Manager on 04/11/23 at 12:08pm revealed: -She administered Resident #3 his vitamin D3. -She did not know Resident #3 did not have any vitamin D3 in the facility for administration. -She did not know how long Resident #3 had been without his medication. Attempted interview with Resident #3 on 04/11/23 at 3:35pm was unsuccessful. Attempted interview with Resident #3's contracted pharmacy on 04/11/23 at 4:00pm was unsuccessful. Attempted interview with Resident #3's Primary Care Provider on 04/01/23 a 4:03pm was unsuccessful. Refer to the interview with the House Manager on 04/11/23 at 4:39pm. Refer to the telephone interview with the Director on 04/11/23 at 4:39pm. _____ Interview with the House Manager on 04/11/23 at 12:08pm and 4:15pm revealed: -All medications were on monthly cycle fill. -The monthly cycle fill medications included oral medication including controlled substances, inhalers, and nasal sprays. -She did not realize the facility staff had to re-order controlled substances, inhaler and nasal sprays. -All medications were delivered once a month. -The Director was responsible for auditing the medication carts. -She did not know how often the Director audited the medication carts.	C 330		

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C 330	Continued From page 24 Telephone interview with the Director on 04/11/23 at 4:39pm revealed: -Medication should be administered as ordered by the Primary Care Provider (PCP). -The facility staff should notify the pharmacy if the medication was not available for administration. -He expected the medication aides to administer medication and document on the MARs correctly for each resident. -He was responsible for auditing the medications in the facility. -He audited the medication 2 to 3 times monthly. -He did not document the findings from the medication cart audit; he would speak to the House Manager about the findings. -He expected the residents to receive all medications ordered by the PCP.	C 330		
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 observations, interviews, and record reviews, the facility failed to ensure staff	C 341		

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immediately documented the administration of medications for 3 of 3 sampled residents (#1, #2 and #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 05/16/22 revealed:
-Diagnoses included diabetes mellitus type II, hyperlipidemia, schizophrenia, and hypertension.
-There was an order for amlodipine (used to treat high blood pressure) 5mg daily.
-There was an order for famotidine (used to treat heartburn) 20 mg twice daily.
-There was an order for metformin (used to control blood sugar) 1000mg twice daily.
-There was an order for atorvastatin (used to decrease cholesterol) 20mg nightly.

Review of signed physician's order dated 12/29/23 revealed an order for mirtazapine (used to treat depression) 15mg 1.5 tablets at bedtime.

Review of Resident #1's March 2023 medication administration record (MAR) revealed:
-The medication aide (MA) failed to document the administration of amlodipine 5mg, citalopram 200mg, vitamin D 1000 units, and acetaminophen 500mg on 03/16/23 at 8:00am.
-The MA failed to document the administration of acetaminophen 500mg and melatonin 3mg on 03/15/23 at 8:00pm.

Review of Resident #1's April 2023 MAR revealed:
-The MA failed to document the administration of amlodipine 5mg on 04/11/23 at 8:00am.
-The MA failed to document the administration of famotidine 20mg on 04/04/23 at 8:00pm and 04/05/23, 04/10/23 and 04/11/23 at 8:00am.

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C 341	Continued From page 26 -The MA failed to document the administration of metformin 1000mg on 04/10/23 and 04/11/23 at 8:00am. -The MA failed to document the administration of mirtazapine 15mg on 04/04/23 at 8:00pm. -The MA failed to document the administration of atorvastatin 20mg on 04/04/23 at 8:00pm. Refer to the interview with the MA on 04/11/23 at 2:50pm. Refer to the interview with the House Manager on 04/11/23 at 12:03pm. Refer to the telephone interview with the Director on 04/11/23 at 4:39pm. 2. Review of Resident #2's current FL-2 dated 01/30/23 revealed: -Diagnoses included paranoid schizophrenia, Parkinson's disease and chronic pulmonary obstructive disease. -There was an order for divalproex ER (used to treat mood) 500mg daily. -There was an order for fenofibrate (used to treat elevated cholesterol) 48mg daily. -There was an order for multivitamin (used as a supplement) daily. -There was an order for lisinopril (used to treat high blood pressure) 2 daily. -There was an order for dorzolamide-timolol (used to decrease pressure) eye drops one drop each eye twice daily. -There was an order for sodium chloride (used as a supplement) 2 twice daily. -There was an order for senna plus (used to treat constipation) 2 twice daily. -There was an order for Advair Diskus (used to treat shortness of breath) 1 puff twice daily. -There was an order for clonazepam (used to	C 341		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES FAMILY HOME	2122 OVERLAND DRIVE DURHAM, NC 27704

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C 341	Continued From page 27	C 341		

treat anxiety) 0.5mg 1 three times daily.
-There was an order for carbidopa-levodopa (used to treat tremors) 25-500mg three times daily.
-There was an order for melatonin (used for sleep) 3mg at night.
-There was an order for olanzapine (used to manage mood disorder) 20mg at night.
-There was an order for docusate sodium (used to treat constipation) 100mg at night.
-There was an order for tamsulosin (used to treat an enlarged prostate) 0.4mg at night.
-There was an order for fluticasone (used for allergies) 50mcg 2 sprays each nostril every morning.

Review of Resident #2's April 2023 medication record administration (MAR) revealed:
-The medication aide (MA) failed to document the administration of divalproex ER 500mg, fenofibrate 48mg, a multivitamin, lisinopril 30mg, and fluticasone nasal spray on 04/10/23 and 04/11/23 at 8:00am.
-The MA failed to document the administration of dorzolamide-timolol eye drops, sodium chloride 1gm, senna plus, and carbidopa-levodopa 25-100 on 04/10/23 and 04/11/23 at 8:00am and on 04/10/23 at 8:00pm.
-The MA failed to document the administration of Advair 250/50 Diskus on 04/10/23 at 04/11/23 at 8:00am and 04/09/23 and 04/10/23 at 8:00pm.
-The MA failed to document the administration of clonazepam 0.5mg on 04/09/23, 04/10/23 and 0/11/23 at 8:00am, 04/10/22 at 2:00pm and 04/10/23 at 8:00pm.
-The MA failed to document the administration of tamsulosin 0.4mg and melatonin 3mg on 04/10/232 at 8:00pm.
-The MA failed to document the administration of olanzapine 20mg and docusate sodium 100mg

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C 341	Continued From page 28 on 04/06/23 and 04/10/23 at 8:00pm. Refer to the interview with the MA on 04/11/23 at 2:50pm. Refer to the interview with the House Manager on 04/11/23 at 12:03pm. Refer to the telephone interview with the Director on 04/11/23 at 4:39pm. 3. Review of Resident #3's current FL2 dated 10/20/22 revealed: -Diagnosis included paranoid schizophrenia. -There was an order for a multi-vitamin (used as a supplement) daily. -There was an order for vitamin D3 (used as a supplement) 1000 units daily. -There was an order for hydrochlorothiazide (used to treat high blood pressure) 25mg daily. -There was an order for benztropine (used to treat tremors) 0.5mg twice daily. -There was an order for haloperidol (used to treat behaviors) 10mg at bedtime. Review of Resident #3's April 2023 medication record administration (MAR) revealed: -The medication aide (MA) failed to document the administration of a multivitamin, vitamin D3, and hydrochlorothiazide 25mg on 04/05/23 and 04/11/23 at 8:00am. -The MA failed to document the administration of benztropine 0.5 mg twice daily on 04/04/23 at 8:00pm, 04/05/23 and 04/11/23 and 8:00am. -The MA failed to document the administration of haloperidol 10mg on 04/04/23 at 8:00pm. Refer to the interview with the MA on 04/11/23 at 2:50pm.	C 341		

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C 341	Continued From page 29 Refer to the interview with the House Manager on 04/11/23 at 12:03pm. Refer to the telephone interview with the Director on 04/11/23 at 4:39pm. _____ Interview with the medication aide (MA) on 04/11/23 at 2:50pm revealed: -She signed the medication administration record (MAR) after administration of medications. -She had not signed the MARs for 04/11/23 at 8:00am because she was busy and had not had time to sign the MARs. Interview with the House Manager on 04/11/23 at 11:40am revealed: -She worked as the MA when the full-time MA was off duty. -She signed the MARs immediately after administering medication to a resident. -She did not know she did not sign the MARs immediately after administering medications in March 2023 and April 2023. -It was an oversight on her part that she did not document on the MARs immediately after administering medications to the residents. Telephone interview with the Director on 04/11/23 at 4:39pm revealed: -The MARs were to be signed by the MA immediately after administration of medications to a resident before administering medication to a second resident. -He expected the MARs to be signed immediately after medications were administered.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration	C 342		

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C 342	Continued From page 30 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) including inaccurate documentation of a blood pressure medication (#3). The findings are: Review of Resident #3's FL-2 dated 10/20/22 revealed: -Diagnosis included paranoid schizophrenia. -There was an order for lisinopril (used to treat high blood pressure) 20mg ½ tablet daily. Review of Resident #3's signed physician's order	C 342		

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C 342	Continued From page 31 dated 03/28/23 revealed an order to discontinue lisinopril 20mg. Review of Resident #3's March 2023 medication administration record (MAR) revealed: -There was an entry for lisinopril 20mg ½ tablet daily with an administration time of 8:00am. -There was documentation lisinopril was administered from 03/29/23 to 03/31/23 at 8:00am. Review of Resident #3's April 2023 MAR revealed: -There was an entry for lisinopril 20mg ½ tablet daily with an administration time of 8:00am. -There was documentation lisinopril was administered from 04/01/23 to 04/04/23 and 04/06/23 to 04/10/23 at 8:00am. Observation of Resident #3's medications on hand on 04/11/23 at 10:50am revealed there was no lisinopril available for administration. Interview of the medication aide (MA) on 04/11/23 at 2:58pm revealed: -She did not know lisinopril had been discontinued. -She only administered the medication that was in Resident #3's plastic bin. -She did not recall seeing lisinopril in Resident #3's plastic bin. -She did not realize she signed lisinopril on the MAR as administered. -She signed the MAR for lisinopril by accident. Interview with the House Manager on 04/11/23 at 11:51am revealed: -She was responsible for receiving and reviewing new orders for the facility. -She would remove any discontinued medications	C 342		

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C 342	Continued From page 32 from the resident's plastic bin. -She recalled removing lisinopril from Resident #3's plastic bin when the order was received. -She should have discontinued lisinopril in March 2023 MAR when she received the order. -She would take a picture of new orders that were sent to the facility and send the picture to the pharmacy to be added or deleted from the MAR. -The pharmacy would send out the next month's MARs a week before they were to start. -She had received April 2023 MARs for review before the discontinued order for lisinopril was received by the pharmacy. -She should have discontinued lisinopril from the MAR when they were reviewed for the upcoming month. Telephone interview with the Director on 04/11/23 at 4:39pm revealed: -The House Manager was responsible for reviewing all new orders. -The House Manager should have discontinued lisinopril from the March 2023 and April 2023 MARs. -He expected the MARs to be accurate. Attempted telephone interview with Resident #3's pharmacy on 04/11/23 at 4:00pm was unsuccessful.	C 342		
C 355	10A NCAC 13G .1006 (d) Medication Storage 10A NCAC 13G .1006 Medication Storage (d) Locked storage areas for medications shall only be by staff responsible for medication administration, the administrator, or the administrator-in-charge. This Rule is not met as evidenced by:	C 355		

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C 355	Continued From page 33	C 355		

Based on observations, interviews, and record reviews, the facility failed to ensure medications were maintained in a safe manner under locked security except when under the direct physical supervision of the staff in charge of the medication cart.

The findings are:

Interview with the medication aide (MA) on 04/11/23 revealed there was a census of 5 residents.

Observation of the medication room on 04/11/23 from 8:05am to 12:30pm revealed:
-The medication room was a closet in the kitchen.
-The medication room was unlocked, and the door was partially opened.
-There were two doors entering the kitchen, one from the dining room and one from the living room.
-There was no staff supervising the unlocked medication door while the MA was providing personal care assistance.
-There were five bins, each containing prescription medications for each resident in the facility.

Interview with the MA on 04/11/23 at 12:20pm revealed:
-The medication room door handle was broken and could not be locked.
-The Director had placed a padlock on the door after the door handle broke.
-The key to the padlock was lost, so the padlock had to be removed.
-There was no lock on the medication door.
-She would lock the dining room door and living room door at night leading to the kitchen.
-She supervised the medication room during the

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C 355	Continued From page 34 day. -She did leave the kitchen and check on residents during the day without locking the doors leading to the kitchen. -The residents do not go in the kitchen. -The medication door had been unlocked since she returned to work on 04/06/23. Interview with the House Manager on 04/11/23 at 12:06pm revealed: -The lock on the medication door was broken. -The staff would lock the doors leading to the kitchen when the staff was not in the kitchen to supervise the medication room. -She noticed the MA was not in the kitchen and the doors leading to the kitchen were not locked. -She did not say anything to the MA about locking the medication door when the MA was not in the kitchen. Telephone interview with the Director on 04/11/23 at 4:39pm revealed: -The medication room should be locked when no under the direct supervision of the MA. -He was notified two days ago key to the medication room door had been lost. -He instructed the staff to keep the doors leading to the kitchen locked when not under direct supervision. -He expected the doors leading to the kitchen to be locked when the mediation room was not under direct supervision of the MA.	C 355		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and	C 367		

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disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure there were readily retrievable records for controlled substances by documenting the receipt, administration, and disposition for 1 of 1 sampled resident (#2).

The findings are:

Review of Resident #2's current FL-2 dated 01/30/23 revealed:
-Diagnoses included paranoid schizophrenia, Parkinson's disease, and chronic pulmonary obstructive disease.
-There was an order for clonazepam (used to treat anxiety) 0.5mg three times daily.

Review of Resident #2's February 2023 medication administration record (MAR) revealed:
-There was an entry for clonazepam 0.5mg take one tablet three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation clonazepam 0.5mg was administered at 8:00am, 2:00pm, and 8:00pm from 02/01/23 to 02/28/23.

Review of Resident #2's March 2023 MAR revealed:
-There was an entry for clonazepam 0.5mg take one tablet three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation clonazepam 0.5mg

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C 367	Continued From page 36 was administered at 8:00am, 2:00pm, and 8:00pm from 03/01/23 to 03/31/23. Review of Resident #2's April 2023 from 04/01/23 to 04/10/23 MAR revealed: -There was an entry for clonazepam 0.5mg take one tablet three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation clonazepam 0.5mg was administered at 8:00am, 2:00pm, and 8:00pm from 04/01/23 to 04/10/23. Review of the medication administration record (MAR) notebook on 04/11/23 at 9:42am revealed: -There were three controlled substance count sheets (CSCS) for clonazepam 0.5mg for Resident #2. -There was a CSCS for 8:00am, 2:00pm, and 8:00pm. -There was a dispensed date of 01/31/23 with 90 tablets dispensed on the pharmacy label. -The 8:00am CSCS was documented from 02/01/23 to 03/31/23 that clonazepam was administered at 8:00am. -The 2:00pm CSCS was documented from 02/01/23 to 03/31/23 that clonazepam was administered at 2:00pm. -The 8:00pm CSCS was documented from 02/01/23 to 03/31/23 that clonazepam was administered at 8:00pm. -There was no CSCS for April 2023. Observation of Resident #2's medication on hand on 04/11/23 at 11:02am revealed: -There were three bubble packages of clonazepam 0.5mg available for administration. -Three bubble packages contained 30 of 30 clonazepam 0.5mg for a total of 90 tablets available for administration.	C 367		

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C 367	Continued From page 37 Review of the MAR notebook on 04/11/23 at 3:31pm revealed: -There was one CSCS for clonazepam 0.5mg for Resident #2. -There was a dispensed date of 03/28/23 with 90 tablets dispensed documented on the pharmacy prescription label. -There was documentation clonazepam was administered three times daily from 04/01/23 to 04/10/23 and at 8:00am and on 04/11/23 at 2:00pm with 58 dosages remaining. Observation of Resident #2's medication on hand on 04/11/23 at 3:33pm revealed: -There were three bubble packages of clonazepam 0.5mg available for administration. -There were two bubble packages that contained 30 of 30 clonazepam 0.5mg tablets. -There was one bubble package that contained 29 of 30 clonazepam 0.5mg tablets. Telephone interview with a pharmacist at the facility's contracted pharmacy on 04/11/23 at 1:57pm revealed: -The pharmacy dispensed 90 clonazepam 0.5mg on 03/28/23. -The clonazepam 0.5mg were dispensed in three bubble packs, each containing 30 tablets. -A CSCS was stapled to each bubble package of controlled substance dispensed. Based on observation, record reviews, and interviews clonazepam was administered 30 times from 04/01/23 to 04/10/23 with 89 of 90 tablets remaining, dispensed on 03/28/23. Interview with the medication aide on 04/11/23 at 3:24pm. -The MA signed the CSCS when she	C 367		

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C 367	Continued From page 38 administered a controlled substance. -She had not signed Resident #2 CSCS for clonazepam for April 2023 until today, 04/11/23, because there was no CSCS in the MAR notebook to sign. -The MA was approached today, 04/11/23, and asked to sign a CSCS for the month of April 2023. -She signed the April 2023 CSCS for Resident #2 from 04/05/23 at 8:00pm to 04/11/23 at 2:00pm. Interview with House Manager on 04/11/23 at 4:15pm revealed: -The April CSCS was not in the MAR notebook. -She located the CSCS in the medication room. -The CSCS had been signed each time the controlled substance was administered. -She did not know why the CSCS had 58 on hand when the total number of clonazepam 0.5mg tablets in the facility was 89. Interview with the Director on 04/11/23 at 4:39pm revealed: -The MAs should sign the CSCS after the controlled substance was prepared for administration. -He expected the MAs to document on the CSCS after the controlled substance was prepared for administration.	C 367		
C 368	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock.	C 368		

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This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews the facility failed to ensure the controlled medication was stored under double lock for 1 of 1 sampled resident (#1) with an order for sleeping medication.

The findings are:

Review of Resident #2's current FL-2 dated 01/30/23 revealed:
-Diagnoses included osteoarthritis, gastroesophageal reflux disease (GERD), hypertension, Parkinson's disease, paranoid schizophrenia, sleep apnea, and benign prostate hypertrophy (BPH).
-There was an order for clonazepam (used to treat anxiety and depression) 0.5mg three times daily.

Observation of the medication room on 04/11/23 at 8:15am revealed:
-The medication door to the medication closet was open.
-The door handle was broken, and the door was unable to be closed and locked.
-There was a double-hinged safety plate placed two feet above the door handle.
-The double-hinged safety plate had a padlock with a key inserted into the double-hinged safety plate.
-The double-hinged safety plate that was secured to the door frame had been broken from the door frame and was attached to the door with the padlock in place and locked.
-There were 5 plastic bins on an industrial cart in the medication closet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032096	A. BUILDING: _____ B. WING _____	R 04/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES FAMILY HOME	2122 OVERLAND DRIVE DURHAM, NC 27704

(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 368	Continued From page 40 -Each plastic bin contained a resident's name and medications for that specific resident. -Resident #2's medications were in a bin labeled with his name. -There was a bubble pack of clonazepam 0.5mg in the plastic bin marked with Resident #2's name. -The clonazepam package had a large "C" stamped on the bubble pack, indicating it was a controlled substance. -There was a black, locked box with a key on the floor in the medication room. -There were no medications in the black, locked box. Interview with the Pharmacist at the facility's contracted pharmacy on 04/11/23 at 1:57pm revealed: -Clonazepam was a schedule IV control substance and required to be kept under lock and key. -It is a controlled substance that can be sought after, abused, and addictive. Interview with the medication aide (MA) on 04/11/23 2:50pm revealed: -Resident #2's clonazepam was stored in the medication room in the plastic bin with all of Resident #2's medications. -Resident #2 was administered clonazepam three times daily. -She knew the door to the medication room was not locked. -The door handle on the medication door was broken and a double-hinged lock with a padlock had been placed on the door. -The key to the padlock was lost and the double-hinged lock had to be removed from the door frame so the MAs could get the medications for administration.	C 368		

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C 368	Continued From page 41 -The medication door had been broken and unlocked since she returned to work on April 6, 2023, after being off for a week. -She knew Resident #2 had a controlled substance. -She did not know there was a black, locked box in the medication closet. -She watched the medication closet door during the day, and she locked the kitchen door and living room door that led to the medication closet which was located in the kitchen. Interview with the House Manager on 04/11/23 at 12:06pm revealed: -Controlled substances were to be locked in the black, locked box in the medication closet. -She did not know the controlled substance was not in the black locked box. -When the MA was not in the kitchen, the kitchen door was locked. -She noticed the medication door was open and unsecured. -She did not say anything to the MA about the medication closet door being opened and unsecured. -She was told a few days ago the key to the medication door had been lost and the double-hinged lock had to be removed from the door frame. Interview with the Director on 04/11/23 at 4:34pm revealed: -All controlled substances were to be under lock and key. -Resident #2's control substance should have been in a locked box. -He was notified two days ago that the key to the medication door had been lost and the hinge from the double-hinged lock had to be removed from the door frame in order to administer	C 368		

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C 368	Continued From page 42 medications. -The facility staff were to lock the door to the kitchen when the staff was not in the kitchen in order to keep the resident away from the unlocked medication door until the medication door could be locked.	C 368		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or	C992		

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C992	Continued From page 43 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 of 2 staff sampled (A) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: Review of Staff A's personnel record revealed: -There was no hire date documented. -There was a job description for a medication aide (MA) dated 02/12/23. -There was no documentation that an examination and screening for the presence of a controlled substance had been completed. Observation on 04/11/23 between 8:15am and 4:30pm revealed: -Staff A worked as a MA. -Staff A provided personal care, administered medications, and cooked and served meals to the residents. Interview with Staff A on 04/11/23 at 2:50pm revealed: -She was hired in February 2023 but did not remember the exact date. -She worked as a MA. -She had a controlled substance screening when she was hired in February 2023; she could not remember the exact date. -The House Manager took her to the physician's office to have the controlled substance screening	C992		

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C992	Continued From page 44 completed. -She did not remember receiving a paper with the results of her controlled substance screening. Interview with the House Manager on 04/11/23 at 4:31pm revealed: -Staff A was hired as a MA in February 2023. -She transported Staff A to the physician's office to have the controlled substance screening. -She received the controlled substance screening results. -She thought she placed the controlled substance screening results in Staff A's personnel record. Telephone interview with the Director on 04/11/23 at 4:34 pm revealed: -Staff A should have had a controlled substance screening. -He thought Staff A had the controlled substance screening at the physician's office. -He did not know the results from Staff A's controlled substance screening were not in Staff A's personnel record. -It was the responsibility of the Director and the Assistant Director to ensure all personnel records were complete.	C992		