Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033009	A. BUILDING: _____ B. WING _____	R 05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MY GUARDIAN ANGEL FAMILY CARE HOME	514 COKEY ROAD ROCKY MOUNT, NC 27801

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C 000	Initial Comments The Adult Care Licensure Section completed an annual and follow-up survey on 05/17/23.	C 000		
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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#1) had blood work completed, a computed tomography (CT) scan for lung cancer screening and an eye exam completed as ordered. The findings are: Review of Resident #1's current FL-2 dated 11/29/22 revealed diagnoses included hypertension, schizophrenia and prediabetes. Review of Resident #1's Resident Register revealed: -Resident #1 was admitted on 02/01/16. -Resident #1 was a smoker. 1. Review of Resident #1's physician's order dated 11/29/22 revealed an order for a low dose computed tomography (CT) scan for lung screening.	C 249	C 249- 1-4 Going forward the Admin. and Bom will maintain daily monitoring and regarding all documentation recieved from the Bom and PPC. also the Admin., will have weekly staff meetings concerning policy and procedure regarding protocol. 6/12/23 Tag 249- Addendum per telephone conversation with Mr. Bryant on 06/20/23 @ 9:39am revealed: Administrator and Bom will ensure daily monitoring of all documentation and orders from the PCP to ensure completion— 06/20/23- [illegible]	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/16/2023

Tag 249-
The Plan of Correction with addendum was reviewed and acknowledged on 06/20/23. Refer to addendums on page 1 of this Statement of Deficiencies— MB

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C 249	Continued From page 1 Review of Resident #1's record revealed there was no documentation the low dose CT scan had been completed. Telephone interview with the medical assistant at Resident #1's primary care provider (PCP) office on 05/17/23 at 3:50pm revealed the CT scan was for lung cancer screening because of Resident #1's history of smoking. Interview with the Administrator on 05/17/23 at 11:15am revealed Resident #1 had not had a CT scan and he was not aware of the order for low dose CT scan to be completed. Refer to interview with the personal care aide (PCA) on 05/17/23 at 4:00pm. Refer to interview with the Administrator on 05/17/23 at 4:05pm. 2. Review of Resident #1's physician's order dated 04/04/23 revealed an order for blood work including a complete blood count (CBC) with differential and platelets, complete metabolic panel 14 (CMP) plus A1C and magnesium, a lipid panel, Valproic acid and prolactin level to be drawn on 05/09/23. Review of Resident #1's record revealed there was no documentation blood work had been completed had been completed. Telephone interview with the medical assistant at Resident #1's primary care provider (PCP) office on 05/17/23 at 3:50pm revealed: -Resident #1 did not have labs drawn as ordered on 05/09/23 as ordered on 04/04/23. -It was important for Resident #1 to have bloodwork completed to ensure blood levels were	C 249	(1.) When taking in New Residents Administrator and BOM will review the admission Packet of the Resident(s) #1 and Contact the primary care DR making sure that any Labs or test need to be ordered before the resident is admitted to the facility. This will be completed 5/31/23 within 30 days	6/30/23

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C 249	Continued From page 2 appropriate, especially the Valproic acid and A1C. -The A1C monitored for blood sugar levels and progression of diabetes. -If the valproic acid was too low, Resident #1's mood may not be well stabilized and, if it was too high, there could be an increase in his liver enzymes that could lead to drowsiness and slurred speech. Interview with personal care aide (PCA) on 05/17/23 at 4:00pm revealed: -She transported the residents to appointments. -She last transported Resident #1 on 04/04/23. -She remembered the sheet with the bloodwork order coming in by fax but she thought it was about results of bloodwork and not an order. -She did not send pictures of the order for bloodwork to the Business Office Manager (BOM) as she was supposed to. Interview with the Administrator on 05/17/23 at 4:05pm revealed he was not aware Resident #1 had blood work ordered or that bloodwork had not been completed. Refer to interview with the PCA on 05/17/23 at 4:00pm. Refer to interview with the Administrator on 05/17/23 at 4:05pm. 3. Review of Resident #1's physician's order dated 02/28/23 revealed an order for an eye exam. Review of Resident #1's record revealed there was no documentation an eye exam had been completed. Interview with the Administrator on 05/17/23	C 249	When taking in New Residents Administrator and BOM will review the admission Packet of the resident(s) it I and contact the primary care Dr. making sure that any labs or test need to be ordered before the resident is admitted to the facility. This will be completed within 30days	6/16/23

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C 249	Continued From page 3 revealed Resident #1 had not seen an eye doctor and he was not aware of the order for an eye exam. Refer to interview with the personal care aide (PCA) on 05/17/23 at 4:00pm. Refer to interview with the Administrator on 05/17/23 at 4:05pm. 4. Review of Resident #1's record revealed documentation of an appointment for follow-up with his primary care provider on 05/17/23 at 10:20am. Telephone interview with the medical assistant at Resident #1's primary care provider (PCP) office on 05/17/23 at 3:50pm revealed Resident #1 had an appointment that morning at 10:20am but he did not attend the appointment, called to cancel or reschedule. Interview with personal care staff on 05/17/23 at 4:00pm revealed: -She did not send a picture of the follow-up appointment to the Business office manager as she was supposed to. -She forgot to write the follow-up appointment for 05/17/23 on the calendar as she should have. Interview with the Administrator on 05/17/23 at 4:05pm revealed he was not aware Resident #1 had an appointment that morning. Refer to interview with the personal care staff on 05/17/23 at 4:00pm. Refer to interview with the Administrator on 05/17/23 at 4:05pm.	C 249	The Administrator, BOM and the PCA will read over the morning documentations and act accordingly, and make the necessary appointments with Resident's #1 Primary Care Doctor. This will be completed within 30 days.	6/16/23
			The Administrator, BOM and the PCA will make sure that the Resident #1 will be taken to the Primary Doctor upon being admitted to the facility, for any appointment needed this will be completed within 30 days.	6/16/23

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C 249	Continued From page 4 Interview with personal care aide (PCA) on 05/17/23 at 4:00pm revealed: -She transported the residents to appointments. -She last transported Resident #1 on 04/04/23. -She was suppose to write new appointments on the calendar. -She was suppose to send a picture of the new orders by text to the business office manager (BOM) before filing new documentation in the resident record. Interview with the Administrator on 05/17/23 at 4:05pm revealed: -The BOM only worked part-time and was only in the facility on Mondays for part of the day. -The BOM was responsible for ensuring all orders were completed including the scheduling of appointments. -The BOM reviewed resident records for medication orders but did not review them on a weekly basis. -The BOM would need to review all documentation to ensure no orders or appoints are missed. -Personal care aide (PCA) were supposed to write new appointments on the calendar and send a picture of the new order to the BOM for follow-up. -He did not know why the PCA had not written appointments on the calendar or sent the pictures of the orders to the BOM but thought she may have been distracted.	C 249	The PCA "will" ~~should~~ follow the rules of documenting and communicating with the BOM as she is instructed to do so, and record the appointments on the Calendar as she was suppose to do. This will be completed within 30 days	6/16/23
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes:	C 257		

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C 257	Continued From page 5 (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods being stored and served to residents were protected from contamination related to observations of unlabeled, and undated foods. The findings are: Observation of the refrigerator freezer in the kitchen on 05/17/23 at 9:35am revealed: -There were sausage links stored in a slide closure storage bag that was not dated or labeled. -There was chicken stored in a slide closure storage bag that was not dated or labeled. Observation of a cupboard on 05/17/23 at 9:37am revealed there were 3 plastic storage bins of breakfast cereal that was not dated or labeled. Observation of the chest freezer on 05/17/23 at 9:43am revealed: -There were several bags of meat stored in a slide closure storage bag that was not dated or	C 257	The Admin. will be responsible for making sure that all left over food brought in to the facility will be dated and labeled. The Admin. will also make sure that any left over food will be placed in a zip lock bag, dated and labeled. Bom will be responsible for all foods being stocked and labeled, and monitor refrigerated food storage and expiration date on a weekly basis 6/16/23	

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C 257	Continued From page 6 labeled. -There was a meat item that was covered in frost and the original package was torn open, exposing the meat. Observation of the stand up freezer on 05/17/23 at 9:58am revealed: -There was a plastic grocery bag that contained meat that was partially wrapped in aluminum foil that was not dated or labeled. -There was a meat item that was covered in frost and the original package was torn open, exposing the meat. Interview with personal care aide (PCA) on 05/17/23 at 9:40am revealed: -She and other staff cooked the food for the residents. -The Administrator was responsible for storing food. -She was not aware items that were not stored in the original package should be dated and labeled. Interview with the Administrator on 05/17/23 at 4:05pm revealed: -He was responsible for the storage of food. -Foods were bought in bulk when possible. -Meats were separated and stored in zip closer storage bags. -He knew items that were not in the original package for storage should be dated and labeled. -He thought he may have gotten distracted and forgot to date and label the stored items. -He did not have a process for checking items after they were stored.	C 257		