

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/11/2023
NAME OF PROVIDER OR SUPPLIER QUAKER MEADOWS FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 125 CAMELLIA GARDEN STREET MORGANTON, NC 28655			
(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 survey on July 6 - 11, 2023, with an exit conference via telephone on July 11, 2023.	C 000			
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any	C 007	Resident #1 and #3 are no longer residents at the facility. Only ambulatory residents will be admitted to the facility. The Administrator Assistant and Administrator will review through pre-admission screenings that any residents being admitted are ambulatory and have no cognitive and physical impairments which would make them unable to evacuate the facility independently. Both the Administrator Assistant and the Administrator will document new residents are ambulatory and have no cognitive or physical impairment that would not allow them to evacuate independently. The Administrator Assistant will monitor all residents for any change in condition to assure they remain cognitively and physically capable to evacuate independently. The Administrator will monitor weekly all residents are ambulatory.	8/25/23	

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

STATE FORM

TITLE

(X5) DATE

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continuation sheet 1 of 55

AUG 22 2023

ADULT CARE LICENSURE SECTION
RALEIGH

Reviewed and acknowledged on 08/25/23 by

Jennifer Fender, RN / jof

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C 007	Continued From page 1 possible changes that may be required to the building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Facility Services when the overall evacuation capability of the residents changed from the evacuation capability listed on the license for 2 of 3 sampled residents (Resident #1 and #3) who were wheelchair bound, had cognitive and physical impairments, and were unable to evacuate the facility independently. The findings are: Review of the facility's current license effective 01/01/23 to 12/31/23 revealed the facility was licensed for six ambulatory residents. Observation of facility on 07/06/23 between 9:30am and 5:00pm revealed: -The facility had a census of three residents. -There was one staff member in the facility. -There was no fire suppression system installed in the facility. -The were three entrances/exits. -Resident #1 and #3 were in wheelchairs, and Resident #2 could ambulate independently without a device. Observation on 07/06/23 at 10:29am revealed: -One staff entrance/exit door was in the office area and the other resident entrance/exit doors were located off the kitchen and the living room.	C 007			

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C 007	Continued From page 2 -The first visitor/staff door was located between the kitchen and dining room (side of facility) and the resident entrance/exit door was in the living room located at the front of the house. -The primary resident exit door in the living room was ground level but was separated by an elevated threshold that was a 90-degree angle, approximately 1.5 inches high from floor level. Observation of a fire drill on 07/06/23 at 4:29pm revealed: -Resident #2 walked from the living room to the front exit door, out to the patio area independently, without verbal or physical assistance. -The Hospice certified nursing assistant (CNA) wheeled Resident #1 over the threshold and through the front exit door, onto the patio. -The second shift personal care aide (PCA) quickly went from a seated position in the living room to Resident #3's room (fifth room on the right side of the hall) as soon the alarm was activated, wheeled Resident #3 up the hallway into the living room and through the exit door. -The drill was completed in 47.6 seconds for all 3 residents, the PCA, and Hospice CNA to exit the building. Observation of a second fire drill on 07/07/23 at 10:40am revealed: -The threshold had been removed at the living room exit door, so that the floor was level inside the living room and leading onto the outdoor patio. -The smoke detector sounded at 10:40am -Staff gave multiple verbal reminders to all residents during the drill, with instructions that a drill was being conducted and they needed to evacuate the building. -The independently ambulatory resident opened	C 007			

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C 007	Continued From page 3 the living room door for Resident #1 and #3 to exit. -Resident #1 exited the building seated in her wheelchair without physical assistance. -It took Resident #1 approximately 10 seconds to exit. -Resident #3 took from 10:40am until 10:44am to make it out of the door in her wheelchair using only the left side of her body to maneuver the wheelchair. -Resident #3's right foot dragged the floor during the drill due to no footrest on the right side of the wheelchair. 1. Review of Resident #1's current FL2 dated 06/21/23 revealed: -Diagnosis included acute encephalopathy (brain disease that alters function or structure). -Ambulatory status was non-ambulatory. -She had a wound to her left leg. -The level of care was assisted living facility. Review of Resident #1's previous FL2 dated 03/09/23 revealed: -Diagnosis included dementia, peripheral artery disease (circulatory condition that reduces blood flow to the lower extremities), sacral Stage I pressure ulcer (a reddened area on the skin, caused by prolonged pressure of the skin onto the bony area of the body). -Ambulatory status was left blank. Review of Resident #1's record revealed: -She had a left above knee amputation in 2019. -She was hospitalized in June of 2023 for osteomyelitis (infection of the bone) of the left stump and currently had an open wound of the left stump, wounds on the right toes, and a sacral stage 1 pressure ulcer.	C 007			

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C 007	Continued From page 4 Review of Resident #1's Resident Register revealed: -It was dated 03/08/23 with an admission date of 03/08/23. -The resident required the use of a wheelchair. Review of Resident #1's care plan dated 03/09/23 revealed: -The facility name was documented as the sister facility located on the same property beside of the family care home. -She had an amputation to one leg and required the use of a wheelchair. -She had limited strength in both upper extremities. -The resident used hearing aids. -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. -The care plan was signed by the physician on 03/09/23. Observation of Resident #1 on 07/06/23 at 12:10pm and 12:31pm revealed: -She had a left leg above knee amputation. -She was able to wheel herself from her room to the living room and dining area without assistance. -She was trying to wheel herself into the bathroom and had to ask for assistance from the PCA. -She was unable to get through the bathroom doorway without assistance from the PCA. Interview with the PCA on 07/06/23 at 12:31pm and 1:10pm revealed: -He had to assist Resident #1 into the bathroom doorway. -She required assistance to transfer from the wheelchair onto the toilet and was not safe to do	C 007			

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C 007	Continued From page 5 it on her own. -She required assistance with transfers by one staff person since her admission. -She was unable to transfer herself safely from any seated position. -Resident #1 was unable to exit the facility during a fire drill without assistance. -She needed more assistance due to her worsening left leg wound. Interview with Resident #1 on 07/06/23 at 4:39pm and 07/07/23 at 2:11pm revealed: - "I would not be able to get out of the building without help." -She could not transfer to the bed from the wheelchair, and vice versa independently. -She had always required the assistance from one staff with transfers. Interview with Resident #1's Power of Attorney (POA) on 07/07/23 at 2:10pm revealed: -They were unsure if she could exit the building in her wheelchair independently. -She went on outings with them and was currently able to bear weight on the right lower extremity and pivot but was not able to lower herself into the car seat without assistance from him. -He did not believe she would be able to lower herself in the bed without assistance. -She had lived at home prior to her admission and was able to do more, but now they relied on staff observations to let them know how she transferred. Confidential interview with staff revealed Resident #1 could not transfer without one person assist for all transfers. Attempted telephone interview with Resident #1's Primary Care Provider on 07/10/23 at 12:22pm	C 007			

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C 007	Continued From page 6 was unsuccessful. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 2. Review of Resident #3's current FL2 dated 06/22/23 revealed: -Diagnosis included secondary malignant neoplasm of the brain (cancer from another area of the body that has spread to the brain). -She was disoriented intermittently. -She was non-ambulatory. -She had vision loss in left eye. Review of Resident #3's Care Plan dated 06/27/23 revealed: -She received full Hospice care due to cancer. -She was ambulatory with a device and had limited range of motion in the upper extremities. -She was paralyzed on the right side. -She required extensive assistance with toileting, ambulation, grooming, and transferring. -She was totally dependent for bathing and dressing. Review of Resident #3's Resident Register dated 06/23/23 revealed: -She required assistance with getting in and out of bed. -She required assistance with positioning and turning. Review of Resident #3's skin assessment dated 06/23/23 revealed the resident was unable to move the right side of her body, including her arm and leg. Observation of Resident #3 on 07/06/23 at 9:30am and on 07/07/23 at 9:30am revealed: -She was sitting in a wheelchair, in the living room	C 007				

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C 007	Continued From page 7 and was unable to move the right side of her body. -She was only able to propel the wheelchair using her left arm and left leg. -There was no footrest on the right side. Interview with the personal care aide (PCA) on 07/06/23 at 1:10pm revealed: -Resident #3 had weakness on the right side and was unable to safely transfer from the bed to the wheelchair without assistance. -She could not propel herself in the wheelchair independently to exit the front of the home. Interview with a second shift PCA on 07/06/23 at 3:42pm revealed: -Staff had to push Resident #3 throughout the facility in the wheelchair. -"Her good side is weak, so she is unable to transfer without assistance, she is unable to move the right side of her body and has right sided facial droop." Based on observations and interviews it was determined that Resident #3 was not able to be interviewed. Confidential interview with a staff revealed: -Resident #3 could not sit up on her own if lying down in the bed. -Staff had to assist her to a sitting position when she was lying flat in bed. -Staff had to assist her with all transfers. Interview with the Administrator Assistant on 07/07/23 at 12:06pm revealed: -She was not aware that Resident #3's current FL2 documented her ambulatory status as non-ambulatory. -She had asked the Hospice PCP to change the	C 007			

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C 007	Continued From page 8 FL2 dated 06/22/23 to ambulatory or semi ambulatory upon admission and they had agreed to do so, but she was not aware the ambulatory status on the FL2 was not updated. -She was under the impression that Resident #3 could transfer from wheelchair to bed and bed to wheelchair without assistance, but was unable to transfer from sofa to wheelchair, toilet to wheelchair, and vice versa without assistance. A second interview with the Administrator Assistant on 07/07/23 at 4:10pm revealed: -She did not perform a pre-admission assessment on Resident #3 prior to admission to the family care home. -She had only observed Resident #3 at the sister facility, when she assisted her into the bed. -Her usual ambulatory assessment included observing a resident stand up, from a seated position and walk to the restroom, but did not include sitting up from a supine position on the bed. Attempted telephone interview with Resident #3's family member on 07/10/23 at 12:25pm was unsuccessful. Attempted telephone interview with Resident #3's Primary Care Provider on 07/10/23 at 12:18pm was unsuccessful. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. Telephone interview with the Administrator on 7/11/23 at 9:40am revealed: -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care.	C 007			

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C 007	Continued From page 9 -She was not aware that Resident #1 and Resident #3 could not evacuate the facility without verbal cueing or physical assistance.	C 007			
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the building was equipped and maintained for 2 of 3 sampled residents (Resident #1 and #3) residing in the facility who were wheelchair bound, had cognitive and physical impairments, and were unable to evacuate the facility independently. The findings are: Review of the facility's current license effective 01/01/23 to 12/31/23 revealed the facility was licensed for six ambulatory residents. Observation in the facility on 07/06/23 between 9:30am and 5:00pm revealed: -The facility had a census of three residents. -There was one staff member in the facility.	C 022	The elevated threshold which was a 90-degree angle and approximately 1.5 inches high from the floor level located at the primary resident door exit was repaired on 7/6/23 at 11:15 pm by the Maintenance Director. The Maintenance Director will monitor weekly there are no design and construction issues which would prevent a safe evacuation from the facility. The Administrator Assistant will make weekly rounds to visually monitor any thresholds which could prevent an evacuation. Any issues will be immediately addressed. The Administrator will monitor monthly there are no design or construction issues which could prevent evacuations.	8/25/23	

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C 022	Continued From page 10 -There was no fire suppression system installed in the facility. -There were three entrances/exits. -Resident #1 and #3 were in wheelchairs, and Resident #2 could ambulate independently without a device. Observation on 07/06/23 at 10:29am revealed: -One staff entrance/exit door was in the office area and the other resident entrance/exit doors were located off the kitchen and the living room. -The first visitor/staff door was located between the kitchen and dining room (side of facility) and the resident entrance/exit door was in the living room located at the front of the house. -The primary resident exit door in the living room was ground level but was separated by an elevated threshold that was a 90-degree angle, approximately 1.5 inches high from floor level. Observation of a fire drill on 07/06/23 at 4:29pm revealed: -Resident #2 walked from the living room to the front exit door, out to the patio area independently, without verbal or physical assistance. -The Hospice certified nursing assistant (CNA) wheeled Resident #1 over the threshold and through the front exit door, onto the patio. -The second shift personal care aide (PCA) quickly went from a seated position in the living room to Resident #3's room (fifth room on the right side of the hall) as soon the alarm was activated, wheeled Resident #3 up the hallway into the living room, over the threshold, and through the exit door. -The drill was completed in 47.6 seconds for all 3 residents, the PCA, and Hospice CNA to exit the building.	C 022			

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C 022	Continued From page 11 Observation of a second fire drill on 07/07/23 at 10:40am revealed: -The threshold had been removed at the living room exit door, so that the floor was level inside the living room and leading onto the outdoor patio. -The smoke detector sounded at 10:40am -Staff gave multiple verbal reminders to all residents during the drill, with instructions that a drill was being conducted and they needed to evacuate the building. -The independently ambulatory resident opened the living room door for Resident #1 and #3 to exit. -Resident #1 exited the building seated in her wheelchair without physical assistance. -It took Resident #1 approximately 10 seconds to exit. -Resident #3 took from 10:40am until 10:44am to make it out of the door in her wheelchair using only the left side of her body to maneuver the wheelchair. -Resident #3's right foot dragged the floor during the drill due to no footrest on the right side of the wheelchair. Interview with the first shift PCA on 07/06/23 at 1:10pm revealed the facility conducted fire drills every month and the maintenance manager kept the records. Interview with the second shift medication aide (MA) on 07/06/23 at 3:10pm revealed she worked 8-hour shifts by herself. Interview with the Administrator Assistant on 07/06/23 at 4:33pm revealed: -The fire drills were conducted quarterly. -One drill was completed on each shift per quarter.	C 022			

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C 022	Continued From page 12 -The fire drill documentation was kept at the sister facility. -She believed the 2 residents in the wheelchairs could exit the facility without assistance. Review of the facility's fire drill policy revealed: -Facility staff to inform the residents that the alarm will be set off for a practice drill. -All residents, staff, and visitors should meet in the main parking lot. -Once the alarm was set off, staff was to make sure all rooms were vacated. -Fire drills were mandatory and must be done once each shift every 3 months. -Fire drill logs must be up to date. Review of the facility's fire drill binder and the midnight census reports for May, June, and July 2023 revealed: -On 05/04/23 at 2:00am, there were 2 residents and 1 PCA in the facility, staff and residents were out within 15 minutes. -On 05/04/23 at 9:45am, there was 1 resident and 1 PCA in the facility, staff and resident were out within 2 minutes. -On 05/04/23 at 3:00pm, there was 1 resident and 1 PCA in the facility, staff and resident were out within 3 minutes and 15 seconds. -In June 2023 at "12 midnight" (no exact date specified), there was a fire in the residents' rooms, 1 PCA and unknown number of residents were out within 15 minutes. -In June 2023 at 12:00am (no exact date specified), there was a fire in the hall shower room, 1 PCA and unknown number of residents were out within 15 minutes. -In June 2023 at 4:15pm (no exact date specified), there was a fire in the main entrance, 1 PCA and unknown number of residents were out within 15 minutes.	C 022			

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C 022	Continued From page 13 -On 07/06/23 at 4:37pm, there were 3 residents and 1 PCA in the facility, staff and resident were out within 1 minute. -On 07/07/23 at 10:40am, there were 3 residents and 1 PCA in the facility, staff and residents were out within 3 minutes. 1. Review of Resident #1's current FL2 dated 06/21/23 revealed: -Diagnosis included acute encephalopathy (brain disease that alters function or structure). -Ambulatory status was non-ambulatory. -She had a wound to her left leg. -The level of care was assisted living facility. Review of Resident #1's previous FL2 dated 03/09/23 revealed: -Diagnosis included dementia, peripheral artery disease (circulatory condition that reduces blood flow to the lower extremities), sacral Stage I pressure ulcer (a reddened area on the skin, caused by prolonged pressure of the skin onto the bony area of the body). -Ambulatory status was left blank. Review of Resident #1's record revealed: -She had a left above knee amputation in 2019. -She was hospitalized in June of 2023 for osteomyelitis (infection of the bone) of the left stump and currently had an open wound of the left stump, wounds on the right toes, and a sacral stage 1 pressure ulcer. Review of Resident #1's Resident Register revealed: -It was dated 03/08/23 with an admission date of 03/08/23. -The resident required the use of a wheelchair. Review of Resident #1's care plan dated 03/09/23	C 022			

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C 022	Continued From page 14 revealed: -The facility name was documented as the sister facility located on the same property beside of the family care home. -She had an amputation to one leg and required the use of a wheelchair. -She had limited strength in both upper extremities. -The resident used hearing aids. -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. -The care plan was signed by the physician on 03/09/23. Observation of Resident #1 on 07/06/23 at 12:10pm and 12:31pm revealed: -She had a left leg above knee amputation. -She was able to wheel herself from her room to the living room and dining area without assistance. -She was trying to wheel herself into the bathroom and had to ask for assistance from the PCA. -She was unable to get through the bathroom doorway without assistance from the PCA. Interview with the PCA on 07/06/23 at 12:31pm and 1:10pm revealed: -He had to assist Resident #1 into the bathroom doorway. -Resident #1 required assistance to transfer from the wheelchair onto the toilet and was not safe to do it on her own. -Resident #1 required assistance with transfers by one staff person since her admission and was unable to transfer herself safely from any seated position. -Resident #1 was unable to exit the facility during a fire drill without assistance.	C 022			

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C 022	Continued From page 15 -Resident #1 needed more assistance due to her worsening left leg wound. Observation of Resident #1 on 07/06/23 at 4:38pm revealed: -She attempted to exit the facility, in the wheelchair, through the living room exit door, without assistance. -After 1 minute and 18 seconds had lapsed, she was physically unable to propel her wheelchair over the threshold without assistance. -She was unable to get out of the facility without physical or verbal assistance. Interview with Resident #1 on 07/06/23 at 4:39pm and 07/07/23 at 2:11pm revealed: -"I would not be able to get out of the building without help." -She could not transfer to the bed from the wheelchair, and vice versa independently. -She had always required one staff person to assist her with transfers. Interview with Resident #1's Power of Attorney (POA) on 07/07/23 at 2:10pm revealed: -They were unsure if she could exit the building in her wheelchair independently. -She went on outings with them and was currently able to bear weight on the right lower extremity and pivot but was not able to lower herself into the car seat without assistance from him. -He did not believe she would be able to lower herself in the bed without assistance. -She had lived at home prior to her admission and was able to do more, but now they relied on staff observations to let them know how she transferred. Confidential interview with staff revealed Resident #1 could not transfer without one person assist	C 022			

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C 022	Continued From page 16 for all transfers. Attempted telephone interview with Resident #1's Primary Care Provider on 07/10/23 at 12:22pm was unsuccessful. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 2. Review of Resident #3's current FL2 dated 06/22/23 revealed: -Diagnosis included secondary malignant neoplasm of the brain (cancer from another area of the body that has spread to the brain). -She was disoriented intermittently. -She was non-ambulatory. -She had vision loss in left eye. Review of Resident #3's Resident Register dated 06/23/23 revealed: -She required assistance with getting in and out of bed. -She required assistance with positioning and turning. Review of Resident #3's Care Plan dated 06/27/23 revealed: -She received full Hospice care due to cancer. -She was ambulatory with a device and had limited range of motion in the upper extremities. -She was paralyzed on the right side. -She required extensive assistance with toileting, ambulation, grooming, and transferring. -She was totally dependent for bathing and dressing. Review of Resident #3's skin assessment dated 06/23/23 revealed the resident was unable to move the right side of her body, including her arm and leg.	C 022			

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C 022	Continued From page 17 Observation of Resident #3 on 07/06/23 at 9:30am and on 07/07/23 at 9:30am revealed: -She was sitting in a wheelchair, in the living room and was unable to move the right side of her body. -She was only able to propel the wheelchair using her left arm and left leg. -There was no footrest on the right side. Interview with the personal care aide (PCA) on 07/06/23 at 1:10pm revealed: -Resident #3 had weakness on the right side and was unable to safely transfer from the bed to the wheelchair without assistance. -She could not propel herself in the wheelchair independently to exit the front of the home. Interview with a second shift PCA on 07/06/23 at 3:42pm revealed: -Staff had to push Resident #3 throughout the facility in the wheelchair. -"Her good side is weak, so she is unable to transfer without assistance, she is unable to move the right side of her body and has right sided facial droop." Interview with the Administrator Assistant and the second shift PCA on 07/06/23 at 4:40pm revealed Resident #3 was unable to evacuate the facility without physical and verbal assistance during the fire drill. Interview with the Administrator Assistant on 07/06/23 at 4:45pm revealed: -She had never completed a fire drill since Resident #3 was admitted. -Resident #3 was admitted to the facility at the end of June 2023.	C 022			

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C 022	Continued From page 18 Based on observations and interviews it was determined that Resident #3 was not able to be interviewed. Confidential interview with a staff revealed: -Resident #3 could not sit up on her own if lying down in the bed. -Staff had to assist her to a sitting position when she was lying flat in bed. -Staff had to assist her with all transfers. Interview with the Administrator Assistant on 07/07/23 at 12:06pm revealed: -She was not aware that Resident #3's current FL2 documented her ambulatory status as non-ambulatory. -She had asked the Hospice PCP to change the FL2 dated 06/22/23 to ambulatory or semi ambulatory upon admission and they had agreed to do so, but she was not aware the ambulatory status on the FL2 was not updated. -She was under the impression that Resident #3 could transfer from wheelchair to bed and bed to wheelchair without assistance, but was unable to transfer from sofa to wheelchair, toilet to wheelchair, and vice versa without assistance. A second interview with the Administrator Assistant on 07/07/23 at 4:10pm revealed: -She did not perform a pre-admission assessment on Resident #3 prior to admission to the family care home. -She had only observed Resident #3 at the sister facility, when she assisted her into the bed. -Her usual ambulatory assessment included observing a resident stand up, from a seated position and walk to the restroom, but did not include sitting up from a supine position on the bed.	C 022			

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C 022	Continued From page 19 Attempted telephone interview with Resident #3's family member on 07/10/23 at 12:25pm was unsuccessful. Attempted telephone interview with Resident #3's Primary Care Provider on 07/10/23 at 12:18pm was unsuccessful. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. Telephone interview with the Administrator on 7/11/23 at 9:40am revealed: -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -She was not aware that Resident #1 and Resident #3 could not evacuate the facility without verbal cueing or physical assistance. The facility failed to ensure the building was compliant with its current license for 6 ambulatory residents resulting in 2 of 3 residents (#1 and #3) who were wheelchair bound with physical and cognitive impairments, that impeded their ability to independently evacuate the building in an emergency. Resident #1 had dementia, an above left knee amputation, and multiple wounds, while Resident #3 had right sided paralysis. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 for this B Violation on 07/06/23.	C 022			

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C 022	Continued From page 20	C 022			
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 3 of 4 direct care staff (Staff A, B and D) were tested upon hire for tuberculosis (TB) disease in compliance with the TB control measures adopted by the Commission for Health Services. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 05/01/23. -There was no facility specific documentation of a TB skin test being administered. Interview with Staff A on 07/07/23 at 3:15pm revealed:	C 140	Tuberculosis testing for all employees will be completed. The Administrator Assistant will assure tuberculosis testing are completed upon employment. The Administrator will review each personnel file to assure compliance that all employees have a tuberculosis screening and any newly hired employees are also screened ongoing for compliance. The Administrator Assistant and Administrator will monitor compliance by completing a personnel file checklist.	8/25/23	

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C 140	Continued From page 21 -She had been providing direct care to residents since 05/01/23. -She as hired as a medication aide on 05/01/23. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 2. Review of Staff B's personnel record revealed: -Staff B was hired on 04/03/23. -There was no facility specific documentation a TB skin test was administered. -There was documentation that a TB skin test was read negative on 04/07/23 with a different facility name listed. Interview with Staff B on 07/10/23 at 2:48pm revealed: -She did receive her first step in April, could not remember TB skin test placement date but was read negative on 04/07/23. -She had been providing direct care to residents since 04/07/23. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 3. Review of Staff D's personnel record revealed: -Staff D was hired on 05/21/23.	C 140			

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C 140	Continued From page 22 -There was no facility specific documentation of a TB skin test being administered. -There was documentation that a TB skin test was administered on 05/24/23 and was read negative on 05/27/23 with a different facility name listed. Attempted telephone interview with Staff D on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated the employee records for each facility -She thought since they were owned by the same company that it was acceptable to share employee records, even though they were two different license numbers. Interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible to ensure personnel records were correct and complete and staff completed required TB screenings and had TB	C 140			

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C 140	Continued From page 23 skin test on file for new staff upon hire. -The Resident Care Coordinator (RCC) helped her with staff records but there was no system in place to audit staff records. -She did not know staff had to have a facility specific TB skin test completed prior to working in that facility. -She did not know staff personnel records had to be facility specific. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records. -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	C 140			
C 141	10A NCAC 13G .0406 (a)(1) Other Staff Qualification 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (1) have a job description that reflects actual duties and responsibilities and is signed by the administrator and the employee;	C 141	Job descriptions will be signed by employees and reviewed with the Administrator Assistant to reflect their actual duties and responsibilities of their job. The Administrator Assistant will review each personnel file to assure job descriptions are completed at time of hire. The Administrator will review personnel files to assure compliance for all current employees and also review all new hires upon employment have a job description. The Administrator Assistant and Administrator will monitor Compliance by completing a personnel file Checklist.	8/25/23	

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C 141	Continued From page 25 facility. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator or 07/11/23 at 9:40am. 2. Review of Staff B's personnel record revealed: -She was hired as a personal care aide (PCA) on 04/03/23. -There was no documentation of a facility specific PCA job description signed by the Administrator and the employee in her personnel record. -She had completed her medication clinical skills on 06/06/23. -There was no documentation of a facility specific MA job description signed by the Administrator and the employee in her personnel record. Interview with Staff B on 07/10/23 at 2:48pm revealed: -She was initially hired as a PCA. -She completed her medications clinical skills on 06/06/23. -She thought she had signed a MA job description but was not certain. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator or 07/11/23 at 9:40am.	C 141			

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C 141	Continued From page 26 3. Review of Staff C's personnel record revealed: -She was hired as a PCA on 04/28/23. -There was no documentation of a facility specific PCA job description signed by the Administrator and the employee in her personnel record. -She had completed her medication clinical skills on 06/06/23. -There was no documentation of a facility specific MA job description signed by the Administrator and the employee in her personnel record. Attempted telephone interview with Staff C on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm and on 07/11/23. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 4. Review of Staff D's personnel record revealed: -She was hired as a PCA on 05/21/23. -There was no documentation of a facility specific PCA job description signed by the Administrator and the employee in her personnel record. Attempted telephone interview with Staff D on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the	C 141			

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NAME OF PROVIDER OR SUPPLIER QUAKER MEADOWS FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 125 CAMELLIA GARDEN STREET MORGANTON, NC 28655			
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C 141	Continued From page 27 Administrator on 07/11/23 at 9:40am. Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -All new staff job descriptions should have been signed by her and each employee. -She was not aware the job descriptions had not been signed. -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated the employee records for each facility -She thought since they were owned by the same company that it was acceptable to share employee records, even though they were two different license numbers. Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible for all personnel records for job descriptions and job duty forms. -She did not know staff personnel records had to be facility specific. -She did not know staff had to have a facility specific job descriptions completed. -She would ensure all staff would have a facility specific job descriptions signed by the Administrator and the employee in the employee's personnel record. -The Resident Care Coordinator (RCC) helped her with staff records but there was no system in place to audit staff records. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed:	C 141			

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C 141	Continued From page 28 -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records. -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	C 141			
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, record reviews and interviews the facility failed to ensure 3 of 4 sampled staff (Staff A, B and C) had been checked on the North Carolina Health Care Personnel Registry (HCPR) prior hire. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired on 05/01/23. -There was no facility specific documentation a Health Care Personnel Registry (HCPR) check was completed.	C 145	North Carolina Health Care Personnel Registry checks will be completed on employees to note if there are any findings on the Registry. The Administrator Assistant will review all findings to assure compliance. The Administrator Assistant and the Administrator will review each personnel file to assure North Carolina Health Care Personnel Registry checks have been completed and there are no adverse findings. All new hires will have completed North Carolina Personnel Registry checks completed upon hire to assure no findings are present. The Administrator Assistant and Administrator will monitor compliance by completing a personnel file checklist.	8/25/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/11/2023
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C 145	Continued From page 29 Interview with Staff A on 07/07/23 at 3:15pm revealed: -She had been providing direct care to residents since 05/01/23. -She as hired as a medication aide on 05/01/23. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 2. Review of Staff B's personnel record on 07/07/23 revealed: -She was hired on 04/03/23. -There was documentation of a HCPR check being completed for Staff B on 07/07/23. Interview with Staff B on 04/10/23 at 2:48pm revealed: -She was hired on 04/03/23. -She had been providing direct care to residents since 04/07/23. -She was told by the administrative assistant that a HCPR check would be completed but was uncertain if the HCPR had been completed. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am.	C 145			

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C 145	Continued From page 30 3. Review of Staff C's personnel record revealed: -She was hired on 04/28/23. -There was documentation of a HCPR check being completed for Staff C on 07/07/23. Attempted telephone interview with Staff C on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated the employee records for each facility -She thought since they were owned by the same company that it was OK to share employee records, even though they were two different license numbers. Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible to ensure personnel records were correct and complete including checking the HCPR for each employee. -The Resident Care Coordinator (RCC) helped her with staff records but there was no system in	C 145			

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C 145	Continued From page 31 place to audit staff records. -She did not know staff had to have a facility specific HCPR completed prior to working in that facility. -She did not know staff personnel records had to be facility specific. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records. -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	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 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 interviews and record reviews the facility failed to ensure that 4 of 4 sampled staff (Staff A, B, C and D) had an appropriate facility criminal background check performed upon hire.	C 147	Criminal background checks will be completed 8/25/23 on all employees. The Administrator Assistant and Administrator will review each personnel file to assure compliance and review employee's criminal background results. All new employees will have criminal background checks completed upon hire by the Administrator Assistant or the Administrator. The Administrator Assistant and Administrator will monitor compliance by completing a personnel file checklist.		

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C 147	Continued From page 32 The findings are: 1. Review of Staff A's personnel record revealed: -She was hired on 05/01/23. -There was no documentation a facility specific criminal background check was completed for Staff A. Interview with Staff A on 07/07/23 at 3:15pm revealed: -She had been providing direct care to residents since 05/01/23. -She as hired as a medication aide on 05/01/23. -She lived within 500 feet of the facility and was on-call 24/7. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 2. Review of Staff B's personnel record revealed: -She was hired on 04/03/23. -There was no documentation a facility specific criminal background check was completed for Staff B. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am.	C 147			

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C 147	Continued From page 33 3. Review of Staff C's personnel record revealed: -She was hired on 04/28/23. -There was no documentation a facility specific criminal background check was completed for Staff C. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 4. Review of Staff D's personnel record revealed: -She was hired on 05/22/23. -There was no documentation a facility specific criminal background check was completed for Staff D. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated	C 147			

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C 147	Continued From page 34 the employee records for each facility -She thought since they were owned by the same company that it was acceptable to share employee records, even though they were two different license numbers. Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible to ensure personnel records were correct and complete including criminal background checks. -The Resident Care Coordinator (RCC) helped her with staff records but there was no system in place to audit staff records. -She did not know staff had to have a facility specific criminal background checks completed prior to working in that facility. -She did not know staff personnel records had to be facility specific. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records. -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	C 147			
C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications	C 148			

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C 148	Continued From page 35 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 4 sampled staff (Staff A, B, C and D) had an examination and screening for the presence of controlled substances completed and results available in the staff personnel records. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired as a medication aide (MA) on 05/01/23. -There was no documentation of a facility specific examination and screening for the presence of controlled substances in staff A's person's personnel file. -There was a picture of a urine drug screen cup without any staff identifier, facility identifier, results or date completed. Interview with Staff A on 07/07/23 at 3:15pm revealed: -She had been providing direct care to residents since 05/01/23. -She was hired as a MA on 05/01/23. -She lived within 500 feet of the facility and was on-call 24/7. Refer to telephone interview with the	C 148	An examination and screening for the presence of controlled substances will be completed for all employees. The Administrator Assistant and Administrator will review each personnel file to assure employees have been screened for the presence of controlled substances. All new hires will have screening for controlled substances before beginning employment. The Administrator Assistant and the Administrator will monitor by completing a personnel file checklist.		

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C 148	Continued From page 36 Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 2. Review of Staff B's personnel record revealed: -She was hired as a personal care aide (PCA) on 04/03/23. -There was no documentation of a facility specific examination and screening for the presence of controlled substances in Staff B's person's personnel file. -There was a picture of a urine drug screen cup without any staff identifier, facility identifier, results or date completed. Interview with Staff B on 07/10/23 at 2:48pm revealed: -She was initially hired as a PCA. -She did remember completing a urine drug screen upon hire on 04/03/23. -She did not know there was only a picture of a urine drug screen cup without any staff identifier, facility identifier, results or date completed. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 3. Review of Staff C's personnel record revealed: -She was hired as a PCA on 04/28/23. -There was no documentation of a facility specific	C 148			

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C 148	Continued From page 37 examination and screening for the presence of controlled substances in staff B's person's personnel file. -There was a picture of a urine drug screen cup without any staff identifier, facility identifier, results or date completed. Attempted telephone interview with Staff C on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 4. Review of Staff D's personnel record revealed: -She was hired as a PCA on 05/21/23. -There was no documentation of a facility specific PCA job description signed by the Administrator and the employee in her personnel record. -There was a picture of a urine drug screen cup without any staff identifier, facility identifier, results or date completed. Attempted telephone interview with Staff D on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am.	C 148			

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C 148	Continued From page 38 Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated the employee records for each facility -She thought since they were owned by the same company that it was acceptable to share employee records, even though they were two different license numbers. Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible to ensure personnel records were correct and complete and staff completed required drug screening test upon hire. -She was not aware of state requirements to have drug screens labeled. -She did not know she needed to label the drug screening tests. -She did not know staff personnel records had to be facility specific. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records.	C 148			

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C 148	Continued From page 39 -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	C 148			
C 166	10A NCAC 13G .0503(a) Medication Administration Competency Evaluati 10A NCAC 13G .0503 Medication Administration Competency Evaluation (a) The competency evaluation for medication administration shall consist of a written examination and a clinical skills validation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, etc, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) rules pertaining to medication administration in adult care facilities; and (10) the facility's medication administration policy and procedures.	C 166	A medical administration competency evaluation 8/25/23 will be completed for all medication aides for medication administration within 60 days as a medication aide. The Administrator Assistant and Administrator will assure each employee has documentation of the competency evaluation in their personnel file. All new hires will also have medical administration competency evaluations once completed in their personnel files. The Administator Assistant and Administrator will monitor by using a personnel file checklist.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/11/2023
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(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 166	Continued From page 40 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a medication skills competency evaluation for medication administration completed within 60 days as a medication aide and documentation available in the staff person's personnel record. The findings are: Review of Staff A's personnel record revealed: -She was hired as a medication aide (MA) on 05/01/23. -There was no documentation of a medication skills competency evaluation for medication administration completed. Interview with Staff A on 07/07/23 at 3:15pm revealed: -She had been administering medications to residents since 05/01/23. -She was also employed as a MA by a sister facility located next door in September of 2021. -She thought she had completed a medication skills competency validation for the family care facility, but was unable to locate the paperwork. Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated the employee records for each facility -She thought since they were owned by the same	C 166			

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C 166	Continued From page 41 company that it was acceptable to share employee records, even though they were two different license numbers. Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible to ensure personnel records were complete and staff completed required training in the specified time frames. -She did not know staff personnel records had to be facility specific. -The facility Resident Care Coordinator (RCC) worked with her and performed audits related to employee records. -The employee record audits occurred monthly and sometimes weekly. -The RCC and the Administrator Assistant kept a running list of items needed to be updated on a white board at the sister facility. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records. -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	C 166			
C 172	10A NCAC 13G .0504 (b) Competency Validation For Licensed Health Pro	C 172			

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/11/2023
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C 172	Continued From page 42 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Task (b) Evaluation and validation of competency shall be performed by the following licensed health professionals in accordance with his or her North Carolina occupational licensing laws: (1) A registered nurse shall validate the competency of staff who perform any of the personal care tasks specified in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter; (2) In lieu of a registered nurse, a licensed respiratory care practitioner may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19), and (21) of Rule .0903 of this Subchapter; (3) In lieu of a registered nurse, a licensed pharmacist may validate the competency of staff who perform the personal care tasks specified in Subparagraph (a)(8) and (11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter; and (4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (a)(27) of Rule .0903 of this Subchapter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 4 sampled staff (Staff D) had completed the competency evaluation and	C 172	A Licensed Health Professional Support task evaluation and validation of competency will be performed by a RN for all employees. All future new hires will also have a Licensed Health Professional Support task evaluation Completed by a RN. The Administrator Assistant and Administrator will monitor compliance by completing a personnel file checklist.	8/25/23	

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C 172	Continued From page 43 validation for Licensed Health Professional Support (LHPS) tasks. The findings are: Review of Staff D's personal care aide (PCA) record revealed: -Staff D's hire date was 05/21/23. -There was documentation of a LHPS competency validation with a completion date of 04/03/23 -The employee signature line had been whited out with Staff D's name written over the white out. -There was a typed date of 04/03/23 listed as the date staff signed. Attempted telephone interview with Staff D on 07/10/23 at 5:00pm was unsuccessful. Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated the employee records for each facility -She thought since they were owned by the same company that it was acceptable to share employee records, even though they were two different license numbers. Interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She did not know Staff D's LHPS competency validation had a completion date of 04/03/23, prior to Staff D's hire date of 05/21/23. -She did not have an answer when asked why	C 172			

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C 172	Continued From page 44 Staff D's LHPS had a completion date prior to Staff D being hired. -She did not have an answer when asked why the employee signature line had been whited out and Staff D's name written over the white out. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records. -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	C 172			
C 230	10A NCAC 13G .0801(a) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an initial assessment of each resident is completed within 72 hours of admission using the Resident Register for 1 of 3 sampled residents (Resident #1). The findings are:	C 230	An initial assessment will be completed for all Residents. The Administrator Assistant will assure for all new admissions an initial assessment is completed within 72 hours of admission using the resident register. All new admission resident assessment will be reviewed with the Administrator once completed and the Administrator shall initial on the assessment that the assessment was reviewed; assuring the 72 hour timeline compliance. The Administrator Assistant will review all new Admissions monthly to assure compliance.		

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C 230	Continued From page 45 Review of Resident #1's current FL2 dated 06/21/23 revealed: -Diagnosis included acute encephalopathy. -Ambulatory status was non-ambulatory. -She had a wound to her left leg. -The level of care was assisted living facility. Review of Resident #1's previous FL2 dated 03/09/23 revealed: -Diagnosis included dementia, peripheral artery disease (circulatory condition that reduces blood flow to the lower extremities), sacral Stage I pressure ulcer (a reddened area on the skin, caused by prolonged pressure of the skin onto the bony area of the body). -Ambulatory status was left blank. Review of Resident #1's Resident Register on 07/06/23 at 3:29pm revealed: -It was dated 03/08/23 with an admission date of 03/08/23. -The resident required the use of a wheelchair. Review of Resident #1's record on 07/06/23 at 3:29pm revealed: -She was admitted to the facility on 05/01/23. -The facility name and admission date were incorrect on the resident register. -There was no other resident register in the record for the admission on 05/01/23. Review of Resident #1's record on 07/07/23 at 9:30am revealed the resident register dated 03/08/23 was missing from her record. A second review of Resident #1's record on 07/07/23 at 10:13am revealed: -The Administrator Assistant had placed a revised resident register in the record.	C 230			

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FORM APPROVEDSTATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL012048

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____

B. WING: _____

(X3) DATE SURVEY
COMPLETED

07/11/2023

NAME OF PROVIDER OR SUPPLIER

QUAKER MEADOWS FAMILY CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

125 CAMELLIA GARDEN STREET

MORGANTON, NC 28655

(X4) ID
PREFIX
TAGSUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)ID
PREFIX
TAGPROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)(X5)
COMPLETE
DATE

C 230

Continued From page 46

-The revised resident register was not in the record upon arrival to the facility on 07/07/23.

Interview with the Administrator Assistant on 07/06/23 at 4:00pm revealed:

-Resident #1 was admitted on 05/01/23.

-Resident #1 was previously admitted on 03/08/23 to the sister facility located next door and discharged on 5/1/23.

-The Power of Attorney wanted her be admitted to the family care facility to receive more one-on-one care

-There was no resident register completed upon admission on 05/01/23.

-The was not aware of the need for new resident register since she came directly from the sister facility, and they were owned by the same company.

Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed:

-She was responsible for the safety of residents and admissions.

-She notified staff on the care that residents required verbally and electronically using a mobile phone application.

-She was responsible for resident registers and records.

-The facility's policy was to complete the resident register upon admission, within 24 hours.

-The facility's Resident Care Coordinator (RCC) worked with her and audited resident records.

-The audits occurred monthly and sometimes weekly.

-The RCC and Administrator Assistant kept a running list of items needed on a white board at the sister facility.

Telephone interview with the Administrator on 07/11/23 at 9:40am revealed:

C 230

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C 230	Continued From page 47 -She had been hired as the Administrator on 04/08/23. -She visited the facility every other Friday. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for completion of resident registers and pre-admission assessments, admission paperwork and placement for multiple facilities. -The Administrator Assistant was responsible for completion of all resident paperwork and this was not currently audited by the Administrator. -She was not aware that Resident #1 did not have a Resident Register for her admission on 05/01/23.	C 230			
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of	C 231	A resident assessment will be completed for all Residents. For new admissions a resident assessment will be completed within 30 days of admission and annually which will include a functional assessment to include psychosocial well being, cognitive status and physical functioning in activities of daily living. The Administrator Assistant will review the resident Assessment with the Administrator to assure compliance. The Administrator will sign the Resident Assessment as verification of the Review for 30 day assessments and annual Assessments. Monthly monitoring will occur by the Administrator to assure assessments are completed timely.		8/25/23

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C 231	Continued From page 48 mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an assessment was completed within 30 days following admission, which included a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 06/21/23 revealed: -Diagnosis included acute encephalopathy. -Ambulatory status was non-ambulatory. -She had a wound to her left leg. -The level of care was assisted living facility. Review of Resident #1's previous FL2 dated 03/09/23 revealed: -Diagnosis included dementia, peripheral artery disease (circulatory condition that reduces blood flow to the lower extremities), sacral Stage I pressure ulcer (a reddened area on the skin, caused by prolonged pressure of the skin onto the bony area of the body). -Ambulatory status was left blank. Review of Resident #1's record on 07/06/23 at 3:29pm revealed: -She was admitted to the facility on 05/01/23. -The care plan was dated 03/09/23. -The care plan was the initial care plan completed	C 231			

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C 231	Continued From page 49 for the admission to the sister facility on 03/08/23 -There was no other care plan in the record. Review of Resident #1's care plan dated 03/09/23 revealed: -The facility name was incorrect. -She had an amputation on one leg and required the use of a wheelchair. -She had limited strength in both upper extremities. -The resident used hearing aids. -The resident required extensive assistance with toileting, ambulation, bathing, dressing, grooming, and transferring. -The care plan was signed by the physician on 03/09/23. Interview with the Administrator Assistant on 07/06/23 at 4:00pm revealed: -Resident #1 was admitted on 05/01/23. -She was previously admitted, on 03/08/23, to the sister facility located next door. -She was discharged from the sister facility on 05/01/23 and admitted to this facility on 05/01/23. -The Power of Attorney wanted her be admitted to the family care facility to receive more one-on-one care -There was no care plan completed within 30 days of admission to the facility on 05/01/23. -The Administrator Assistant was not aware of the need for new care plan for the admission on 05/01/23, since both facilities were owned by the same company. Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible for the safety of residents and admissions. -She notified staff on the care that residents required verbally and electronically using a mobile	C 231			

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C 231	Continued From page 50 phone application. -She was responsible for care plans and resident records. -The facility's policy was to complete the care plan within 14 days of admission. -The facility's Resident Care Coordinator (RCC) worked with her and audited resident records related to care plans. -The audits occurred monthly and sometimes weekly. -The RCC and Administrator Assistant kept a running list of items needed on a white board at the sister facility. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility every other Friday. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for completion of care plans, admission paperwork, and placement for multiple facilities. -The Administrator Assistant was responsible for completion of all resident paperwork and this was not currently audited by the Administrator. -She was not aware that Resident #1 did not have a Care Plan for her admission on 05/01/23.	C 231			
C 613	10A NCAC 13G .1701 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL POLICES & PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of	C 613			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/11/2023
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C 613	Continued From page 51 hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 4 sampled staff (Staff A, B, C and D) received facility specific infection prevention and infection control training within 30 days of hire and annually. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired as a medication aide (MA) on 05/01/23. -There was no documentation of a facility specific infection prevention and infection control training in Staff A's personnel record. Interview with Staff A on 07/07/23 at 3:15pm revealed: -She had been providing direct care to residents since 05/01/23. -She was hired as a MA on 05/01/23. -She lived within 500 feet of the facility and was on-call 24/7. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am.	C 613	All employees will complete an infection prevention and infection control training. All new hires will complete infection prevention and infection control training within 30 days of the hire date and annually. The Administrator Assistant will monitor new hires have completed the trainings. The Administrator Assistant and Administrator will review monthly what trainings are needed by employees and schedule trainings as needed to assure compliance. A checklist of training dates will be monitored by the Administrator Assistance and the Business Office Manager.	8/25/23	

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C 613	Continued From page 52 2. Review of Staff B's personnel record revealed: -She was hired as a personal care aide (PCA) on 04/03/23. -There was no documentation of a facility specific infection prevention and infection control training in Staff B's personnel record. Interview with Staff B on 07/10/23 at 2:48pm revealed: -She was initially hired as a PCA. -She could not recall if she had completed infection control training. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. 3. Review of Staff C's personnel record revealed: -She was hired as a PCA on 04/28/23. -There was no documentation of a facility specific infection prevention and infection control training in Staff C's personnel record. Attempted telephone interview with Staff C on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am.	C 613			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/11/2023
NAME OF PROVIDER OR SUPPLIER QUAKER MEADOWS FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 125 CAMELLIA GARDEN STREET MORGANTON, NC 28655			
(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 613	Continued From page 53 4. Review of Staff D's personnel record revealed: -She was hired as a PCA on 05/21/23. -There was no documentation of a facility specific infection prevention and infection control training in Staff D's personnel record. Attempted telephone interview with Staff D on 07/10/23 at 5:00pm was unsuccessful. Refer to telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm. Refer to telephone interview with the Administrator Assistant on 07/11/23 at 8:22am. Refer to telephone interview with the Administrator on 07/11/23 at 9:40am. Telephone interview with the Administrator Assistant on 07/10/23 at 2:55pm revealed: -The staff personnel records were in one employee binder on 07/07/23 which included the sister facility located on the same property. -There was only one binder per employee that was shared between this facility and the sister facility. -She was not aware she should have separated the employee records for each facility -She thought since they were owned by the same company that it was acceptable to share employee records, even though they were two different license numbers. Telephone interview with the Administrator Assistant on 07/11/23 at 8:22am revealed: -She was responsible to ensure personnel records were correct and completed. -She did not know staff did not have the infection	C 613			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL012048	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/11/2023
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C 613	Continued From page 54 control training in their staff records. -She stated that upon hire, she reviewed infections control with all new staff members. Telephone interview with the Administrator on 07/11/23 at 9:40am revealed: -She had been hired as the Administrator on 04/08/23. -She visited the facility twice a month. -Her responsibilities included the overall operations of the facility and resident care. -The Administrator Assistant was responsible for employee records and training for multiple facilities. -She was not aware she needed to have separate employee personnel records. -She currently audited the employee files maintained by the Administrator Assistant for accuracy.	C 613			