

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL033009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/06/2024
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NAME OF PROVIDER OR SUPPLIER
MY GUARDIAN ANGEL FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**514 COKEY ROAD
ROCKY MOUNT, NC 27801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on 06/06/24.	C 000		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medications were safely secured from residents' access to medication which was in a plastic cup on the kitchen counter. The findings are: Review of the facility's undated medication storage policy revealed all prescription and non-prescription medication should be stored in a safe manner, under locked cabinet at all times except when under the immediate or direct physical supervision of staff in charge of medication administration. Review of the facility's undated medication administration policy revealed: -If a medication is prepared for administration in advance the following procedure should be implemented to keep the drugs identified up the point of administration and protect them from contamination and spillage. -Medication should be dispensed in a sealed package.	C 353	To rectify the cited deficiency of improper storage, in compliance to the violation of Rule 10A NCAC 13G 1006; My Guardian Angel Family Care Home will correct the deficit by the procedure as the policy dictates on the matter of medication storage. Medications shall remain locked secured in storage until it is time for the medication aide to administer the prescribed medication, either prior to the designated hour, or the hour allotted.	8-2-2024 6-9-24

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

[Signature]

TITLE

Aspirin

(X6) DATE

8-2-2024

If continuation sheet 1 of 3

R5ET11

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C 353	Continued From page 1 -Medication not dispensed in a sealed and labeled package should be kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name. -A separate container should be used for each client and each planned administration of the medication and label. -All containers should be placed together on a separate tray that is labeled with the time for administration and store in a locked area. Observation of the kitchen counter behind a dining room table on 06/06/24 at 11:59am revealed: -There were four residents eating lunch at a dining room table. -There was a kitchen counter behind one resident (WALL) -There were two clear plastic cups with a lid that had two resident first names written in permanent black marker on the outside of the plastic cups. -There was a clear plastic lid secured on top of the clear plastic cup. -One clear plastic cup contained one Gabapentin 300mg capsule (Gabapentin is used to treat nerve pain). -The second clear plastic cup contained one Proloxin 10mg tablet (Proloxin is used to treat schizophrenia). Attempted telephone interview with a medication aide (MA) on 06/06/24 at 2:19pm was unsuccessful. Telephone interview with a pharmacist with the facility's contracted pharmacy on 06/06/24 at 2:25pm revealed: -There was a risk of drowsiness, which could lead to a fall if a resident consumed the Proloxin tablet	C 353	This shall be deemed protocol as best practice, for ensuring that all medications are locked secured to prevent any medication incidents, prevent to medication error with regard to the resident's medication rights, privacy, not being easily accessible, visible nor unsecured to mitigate the risk of error, from re-occurring again. Medication training has been implemented to establish competency and identify the dangers of handling medication improperly, where training was conducted by the designated RN with testing to: comprehension, demonstration in protocol, safety for adherence regarding accountability	06-24-24 6-9-24	

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C 353	Continued From page 2 or the Gabapentin capsule. -All medications should be safely secured from residents to prevent a resident from taking medications that they were not prescribed and to prevent the diversion of medications. Interview with the Administrator on 06/06/24 at 1:50pm revealed: -The MA that worked this morning prepared two residents' medications prior to the scheduled time the medication was to be administered. -The medications were scheduled to be administered to each resident after lunch. -The MA that worked this morning left one Proloxin 10mg tablet and one Gabapentin 300mg capsule in each clear plastic cup. -He and all MAs were responsible to ensure all medications were secured and locked from resident's access. -The MA thought she was helping him by preparing the medication for two residents, however MAs were trained to follow the facility policy to administer medications to a resident and observe the resident take the medication.	C 353	The responsible person will be Administrator in Charge, with the frequency of monitoring on a weekly basis, in surveying the facility for error of unsecured storage of medications having been observed in a cup with the resident name, left unattended, easily accessible and visible. The Administrator in Charge will observe those medication and personnel follow protocol in maintaining the medication cart, lock under key and demonstrate medications being administered under North Carolina Administrative Code. This plan of correction shall be in compliance immediately at the effective date of the plan of correction being signed	8-2-2024 6-9-24	