STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092320	A. BUILDING: _____ B. WING _____	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARENTCARE ASSISTED LIVING	3720 VESTA DRIVE RALEIGH, NC 27603

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 9, 2024.	C 000		
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 interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff B and Staff C) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) prior to hire at the facility. The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide (PCA) on 12/15/23. -There was no Health Care Personnel Registry (HCPR) check for Staff B. Refer to interview with the Administrator/Owner on 10/09/24 at 1:53pm. 2. Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 12/01/23. -There was no Health Care Personnel Registry (HCPR) check for Staff C. Refer to interview with the Administrator/Owner	C 145		

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C 145	Continued From page 1 on 10/09/23 at 1:53pm. _____ Interview with the Administrator/Owner on 10/09/24 at 1:53pm revealed: -She was responsible for hiring staff and for personnel files. -She completed criminal background checks for staff, but had not completed a Health Care Personnel Registry (HCPR) check on Staff B or Staff C. -She was not aware she needed to complete an HCPR check before staff started working in the facility.	C 145		
C 153	10A NCAC 13G .0501 (a and b)) Personal Care Training And Competency 10A NCAC 13G .0501 Personal Care Training And Competency (a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills;	C 153		

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C 153	Continued From page 2 (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff members (Staff C) who provide personal care to residents completed an 80-hour personal care aide training and competency evaluation program. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a personal care aide (PCA) on 12/01/23. -Staff C had no documentation of the completion of an 80-hour PCA training program. Interview with the Administrator/Owner on 10/09/24 at 1:53pm revealed: -Staff C was hired 12/01/23. -Staff C had not completed an 80-hour PCA training program. -She had been unable to schedule an 80-hour PCA training course at the facility because the	C 153		

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C 153	Continued From page 3 nurse who did the training had been busy. -She was not aware the 80-hour PCA training program should be completed within 6 months of hire at the facility. Attempted telephone interview with Staff C on 10/09/24 at 2:31pm was unsuccessful.	C 153		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled residents (#1, #3) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL2 dated 08/01/24 revealed diagnoses included Huntington's disease, dysphagia, unspecified protein calorie malnutrition, and chronic rhinitis.	C 202		

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C 202	Continued From page 4 Review of Resident #1's Resident Register revealed an admission date of 10/10/23. Review of Resident #1's record revealed there was no documentation of a 1st step or 2nd step tuberculosis (TB) test for Resident #1. Interview with the Administrator/Owner on 10/09/24 at 9:10am revealed: -Residents usually had a TB test before admission to the facility. -The residents' 2nd step TB test was usually administered in 2 weeks after admission and was usually given by the residents' primary care provider (PCP). -She was unsure why Resident #1 did not have a 1st step or 2nd step TB test. -She must have overlooked Resident #1 not having a 1st step or 2nd step TB test in his record. 2. Review of Resident #3's current FL2 dated 05/21/24 revealed diagnoses included dementia, left femur fracture, hypertension, history of falls, left artificial hip, and muscle weakness. Review of Resident #3's Resident Register revealed an admission date of 05/24/24. Review of Resident #3's record revealed: -There was documentation Resident #3 was given a tuberculosis (TB) test on 05/15/24 and the result was documented as negative on 05/18/24. -There was no documentation of a 2nd step TB test for Resident #3. Interview with the Administrator/Owner on 10/09/24 at 12:15pm revealed: -Resident #3 received hospice services.	C 202		

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C 202	Continued From page 5 -She thought she had informed Resident #3's hospice nurse of Resident #3 needing a 2nd step TB test. -She did not think Resident #3 had a 2nd step TB test.	C 202		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure medication was available to be administered as ordered for 1 of 3 sampled residents (#1) as evidenced by the facility not having a medication used to treat allergic reactions for a resident with a tree nut allergy. The findings are: 1. Review of Resident #1's current FL2 dated 08/01/24 revealed: -Diagnoses included Huntington's disease, dysphagia, unspecified protein calorie malnutrition, and chronic rhinitis. -There was an order for Epinephrine Auto-injector pen 0.3mg/0.3ml administer subcutaneously as needed for allergic reaction (Epinephrine	C 330		

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C 330	Continued From page 6 Auto-injector is a device used to inject medication that treats severe allergic reactions). Review of Resident #1's Resident Register dated 10/10/23 revealed Resident #1 had a tree nut allergy. Review of Resident #1's after visit summary from a neurologist's office dated 08/02/24 revealed: -Resident #1 had a tree nut allergy. -Resident #1's reaction to tree nuts was anaphylaxis (Anaphylaxis is a medical term for a severe, life-threatening allergic reaction which can occur within seconds or minutes of exposure to an allergen). Observation of Resident #1's medications on hand on 10/09/24 at 11:35am revealed Resident #1 did not have an Epinephrine Auto-injector pen. Review of Resident #1's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Epinephrine injection 0.3mg, inject 0.3ml (0.3mg) subcutaneously as needed for allergic reactions scheduled as a PRN medication (PRN is a medical abbreviation for as needed). -There was no documentation that Epinephrine injection was administered from 08/01/24 to 08/31/24. Review of Resident #1's September 2024 eMAR revealed: -There was an entry for Epinephrine injection 0.3mg, inject 0.3ml (0.3mg) subcutaneously as needed for allergic reactions scheduled as a PRN medication. -There was no documentation that Epinephrine injection was administered from 09/01/24 to	C 330		

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C 330	Continued From page 7 09/30/24. Review of Resident #1's October 2024 eMAR revealed: -There was an entry for Epinephrine injection 0.3mg, inject 0.3ml (0.3mg) subcutaneously as needed for allergic reactions scheduled as a PRN medication. -There was no documentation that Epinephrine injection was administered from 10/01/24 to 10/09/24. Interview with Resident #1's family member on 10/09/24 at 12:58pm revealed: -Resident #1 had been allergic to tree nuts since he was a child. -Resident #1's reaction to tree nuts was hives, wheezing, and shortness of breath. -He could not recall Resident #1 ever requiring emergency care for his tree nut allergy. Interview with the Administrator/Owner on 10/09/24 at 2:26pm revealed: -Resident #1 had an Epinephrine Auto-injector pen when he was admitted to the facility last year. -Resident #1's Epinephrine Auto-injector pen must have expired, and she did not order a new pen. -The staff at the facility was aware Resident #1 had a tree nut allergy. -Resident #1 did not take much food or liquid by mouth because he received feedings via gastrostomy tube (A gastrostomy tube is a tube inserted into the stomach used to give medications, liquids, and liquid food). -She was not aware of Resident #1 having any allergic reactions since he was admitted to the facility. Interview with a pharmacist at the facility's	C 330		

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C 330	Continued From page 8 contracted pharmacy on 10/09/24 at 12:49pm revealed: -The pharmacy last dispensed an Epinephrine Auto-injector for Resident #1 on 06/01/22 when he resided at another facility. -The pharmacy had not dispensed an Epinephrine Auto-injector for Resident #1 since he was admitted to the facility on 10/10/23. -Epinephrine Auto-injector pens were used to slow the need for emergency care when exposed to an allergen. -If a person needed an Epinephrine Auto-injector pen and did not have it, this created a more urgent situation if the person was having an allergic reaction. Interview with Resident #1's primary care provider (PCP) on 10/09/24 at 3:15pm revealed: -Resident #1 should have an Epinephrine Auto-injector pen available in the facility. -If Resident #1 did not have an Epinephrine Auto-injector pen and was exposed to an allergen, he was at risk for anaphylaxis. Based on observations and record reviews, Resident #1 was not interviewable.	C 330		