STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081053	A. BUILDING: _____ B. WING _____	R-C 04/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 2	141 FOX RUN FOREST CITY, NC 28043

(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 04/20/21.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (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 Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (Resident #3) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #3's current FL2 dated 02/11/21 revealed diagnoses included schizophrenia, moderate alcohol use disorder, and severe tobacco use disorder. Review of Resident #3's Resident Register revealed an admission date of 02/11/21. Review of Resident #3's immunization records revealed:	C 202		

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C 202	Continued From page 1	C 202		

-There was a Tuberculosis (TB) Annual Screening Form dated 02/10/21 at 3:00pm.
-The form was completed by a nurse from a local mental health services provider.
-The TB screening form included questions related to unexplained productive cough, unexplained fever, night sweats, shortness of breath/chest pain, unexplained weight loss or loss of appetite, and unexplained fatigue.
-The resident responses to all the screening questions had been documented as "no."

Interview with the Facility Manager on 04/20/21 at 10:25am revealed:
-Resident #3 had been an inmate at a local correctional facility.
-The local mental health services provider had requested placement for Resident #3 at the facility.
-The facility Manager told the local mental health services provider nurse that a TB skin test would need to be completed before Resident #3 could be admitted to the facility.
-The nurse from the local mental health services provider stated the local health department was unable to perform TB skin testing due to the COVID-19 pandemic and a TB screening form would be completed instead.
-The Manager called Resident #3's primary care provider (PCP) on 04/12/21 to setup an appointment to complete a TB skin test.
-The PCP stated the TB skin test could not be administered until 4 weeks after Resident #3's last COVID-19 vaccine which had been completed on 04/02/21.

Telephone interview with a nurse from the local correctional facility on 04/20/21 at 10:40am revealed:
-Resident #3 had been an inmate in their facility

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C 202	Continued From page 2 from 12/12/20 to 02/11/21. -They screened inmates for TB by asking them questions upon admission to the correctional facility, however unless an inmate answered yes to a TB screening question no further evaluation occurred. Telephone interview with the Registered Nurse (RN) from the local mental health services provider on 04/20/21 at 1:47pm revealed: -He had completed the TB screening form with Resident #3 on 02/10/21. -On 02/10/21, the local health department had not been doing TB skin tests, due to COVID-19 pandemic restrictions. -The TB screening form had been completed in lieu of TB skin testing. -If Resident #3 had answered yes to any of the screening questions, the resident would have been taken to the local hospital for a chest x-ray evaluation for TB. Telephone interview with Resident #3's PCP office on 04/20/21 at 2:33pm revealed: -Resident #3 was last seen in their office on 02/11/21. -Resident #3 would receive a TB skin test "next week" during a scheduled appointment. Attempted telephone interview with the local health department on 04/20/21 at 10:31am was unsuccessful. Attempted telephone interview with the Administrator on 04/20/21 at 2:25pm was unsuccessful.	C 202		
C 315	10A NCAC 13G .1002(a) Medication Orders	C 315		

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C 315	Continued From page 3 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interview and record review the facility failed to ensure contact with a resident's prescribing practitioner for clarification of an order for medication to treat elevated blood sugar for 1 of 3 sampled residents (Resident #1). The finding are: Review of Resident #1's current FL2 dated 02/09/21 revealed: -Diagnoses included hypertension, diabetes, depression, seizure disorder, and intellectual disability. -There was an order for Humalog 100 units/ml, (used to lower elevated blood sugar levels) 10 units subcutaneously three times a day. Interview with Resident #1 on 04/20/21 at 8:27am revealed he was diabetic, had finger stick blood sugar (FSBS) checks 4 times a day and received insulin 3 times a day.	C 315		

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C 315	Continued From page 4 Review of Resident #1's Medication Administration Record (MAR) dated 02/08/21 through 03/07/21 revealed there was an entry for Humalog 100u/ml, 3-13 units under the skin three times a day per sliding scale, max dose 39 units per day. Review of Resident #1's MAR dated 03/08/21 through 04/07/21 revealed there was an entry for Humalog 100u/ml, 3-13 units under the skin three times a day per sliding scale, max dose 39 units per day. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed there was an entry for Humalog 100u/ml, 3-13 units under the skin three times a day per sliding scale, max dose 39 units per day. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/20/21 at 10:03am revealed: -She was unaware the facility was administering 10 units three times a day, rather than using a sliding scale as was entered on the MAR. -Resident #1 had an order for 10 units of Humalog, three times a day, from 04/03/19 until 06/16/20 when it was changed to 3-13 units per sliding scale, three times a day with a max dose of 39 units. -Resident #1's Primary Care Physician (PCP) "always" sent e-prescriptions for medication orders. -The pharmacy did not have what the sliding scale order was; the PCP would have given that to the facility. -They received another e-prescription on 12/14/20 for 3-13 units and dispensed it on 02/01/21, 03/03/21 and 04/02/21.	C 315		

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C 315	Continued From page 5 -The pharmacy received a copy of Resident #1's FL2 dated 02/09/21 but they did not accept medications listed on it as orders. -The pharmacy printed all MARs for the facility. Interview with the Facility Manager on 04/20/21 at 10:01am, 10:15am and 1:10pm revealed: -Resident #1 went to his PCP with the facility's Administrator, on 06/09/20 at which time his FL2 was signed. -The PCP signed the FL2 which listed 10 units of Humalog as his current insulin dose. -He thought the PCP and the pharmacy considered medications on the FL2 as orders. -He did not recall Resident #1's PCP providing him with a sliding scale for administering the Humalog. -Whenever Resident #1 went to the PCP, staff were instructed to "keep doing what we are doing". -He was not notified of an order written on 06/16/20 because he was "never" notified when the PCP sent e-prescriptions to the pharmacy. -When he received the July 2020 MAR the Humalog was listed as 3-13 units three times a day per sliding scale so he contacted the pharmacy to see why it was listed that way. -The pharmacy said the PCP should send a sliding scale and since he did not receive a sliding scale from the PCP he assumed it was a misprint so he continued to administer 10 units of Humalog three times a day as was listed on the FL2 dated 06/09/20. He never clarified the order with the pharmacy or the PCP and continued to administer 10 units of Humalog, three times a day and continued to assume the 3-13 units Humalog entry was a misprint on all MARs from August 2020 through February 2021, -The Administrator again took Resident #1 to the	C 315		

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C 315	Continued From page 6	C 315		

PCP on 02/09/21 and had the current FL2 dated 02/09/21 signed at that appointment.
-The Administrator did not inform him of any medication changes discussed at that appointment.
-When he received the March 2021 and April 2021 MAR the Humalog was still entered as 3-13 units per sliding scale and again he did not clarify the order with the PCP or the pharmacy but continued to administer 10 units three times a day.

Interview with the Administrator on 04/20/21 at 1:17pm revealed:
-He could not remember if he took Resident #1 to his PCP appointments but if the Facility Manager said he did, he "probably" did.
-When he took papers to the PCP for a signature he brought them back to the facility.
-He did not remember if he returned papers from the PCP.
-He did not recall any conversations about insulin/Humalog at Resident #1's PCP appointments.
-The Facility Manager was responsible for ensuring all resident paperwork and orders were correct.

Interview with the Facility Manager on 04/20/21 at 1:17pm revealed:
-He "normally" sent a paper with staff when they took residents to the PCP's office so the PCP could write out any instructions or communicate any changes.
-He did not have any paperwork from appointments other than the signed FL2's.

Interview with the Supervisor-in-Charge (SIC) on 04/20/21 at 2:09pm revealed:
-She started working at the facility about a month

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C 315	Continued From page 7 ago. -When the Facility Manager trained her she had been instructed to administer 10 units of Humalog three times a day to Resident #1, even though the MAR entry was written to give 3-13 units per sliding scale, three times a day. Interview with Resident #1's PCP on 04/20/21 at 11:09am revealed: -He had never received a call from the facility to clarify the sliding scale insulin order. -Resident #1 was seen at his office on 06/16/20 and changed to sliding scale Humalog at that appointment. -The sliding scale Humalog was discussed with the facility staff who accompanied him on the visit. -Resident #1 was seen again in his office on 02/09/21 and the sliding scale Humalog order was again discussed with staff. -He signed a FL2 on 02/09/21 but thought of the FL2 as a review of medications and not an actual order. -Orders for Humalog were always sent to the pharmacy as an e-prescription. -The most recent prescription he wrote for sliding scale Humalog was on 03/03/21 and he only sent it to the pharmacy as there was no office visit with Resident #1 on that day. -He wanted Resident #1 to receive Humalog based upon his blood sugar level because his blood sugars were typically high. -Depending upon what Resident #1's blood sugar level was, administering ten units of Humalog three times a day may be too much Humalog and that could cause him to have dangerously low blood sugar.	C 315		

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C 330	Continued From page 8	C 330		
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: TYPE B VIOLATION Based on interviews, and record reviews, the facility failed to administer a medication as ordered by the licensed prescribing practitioner and in accordance with the facility's policy for 1 of 3 sampled residents (#1) related to a fast-acting insulin. The findings are: Review of Resident #1's current FL2 dated 02/09/21 revealed: -Diagnoses included hypertension, diabetes, depression, seizure disorder, and intellectual disability. -Humalog 100 units/ml, (used to lower elevated blood sugar levels) 10 units subcutaneously three times a day was entered as one of Resident #1's medications. Interview with Resident #1 on 04/20/21 at 8:27am revealed he was diabetic, had finger stick blood sugar (FSBS) checks 4 times a day and received insulin 3 times a day.	C 330		

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C 330	Continued From page 9 Review of Resident #1's Medication Administration Record (MAR) dated 02/08/21 through 03/07/21 revealed: -There was an entry for Humalog 100u/ml, 3-13 units under the skin three times a day per sliding scale, max dose 39 units per day. -Humalog was documented as administered for 84 of 84 opportunities but the quantity of insulin administered was not documented. -FSBSs ranged from 98 to 443. Review of Resident #1's MAR dated 0308/21 through 04/07/21 revealed: -There was an entry for Humalog 100u/ml, 3-13 units under the skin three times a day per sliding scale, max dose 39 units per day. -Humalog was documented as administered for 90 of 90 opportunities but the quantity of insulin administered was not documented. -FSBSs ranged from 139-355. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed: -There was an entry for Humalog 100u/ml, 3-13 units under the skin three times a day per sliding scale, max dose 39 units per day. -Humalog was documented as administered for 46 of 46 opportunities from 04/05/21 through 8am on 04/20/21 but the quantity of insulin administered was not documented. -FSBSs ranged from 98-311. Review of Resident #1's FSBS records dated February 2021, March 2021 and April 2021 revealed: -There was documentation of Resident #1's FSBS checks 4 times a day from February 1, 2021 through February 28, 2021 for a total of 112 FSBS.	C 330		

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C 330	Continued From page 10 -There was documentation of 106 of 112 FSBS less than or equal to 350 which according to the SSI he would receive 9 or less units of insulin. -There was documentation of Resident #1's FSBS checks 4 times a day from March 1, 2021 through March 31, 2021 for a total of 124 FSBS. -There was documentation of 123 of 124 FSBS less than or equal to 350 which according to the SSI he would receive 9 or less units of insulin. -There was documentation of Resident #1's FSBS checks 4 times a day from April 1, 2021 through April 20, 2021 at 8am for a total of 77 FSBS. -There was documentation of 77 of 77 FSBS less than or equal to 350 which according to the SSI he would receive 9 or less units of insulin. Interview with the Facility Manager on 04/20/21 at 10:01am, 10:15am and 1:10pm revealed: -He thought Resident #1 received 10 units of insulin 3 times a day and that was what he administered each time he initialed the MAR. -He did not know why the insulin entry on the MAR was written as give 3-13 units per sliding scale. -Resident #1 went to his PCP with the facility's Administrator, on 06/09/20 at which time his FL2 was signed. -The PCP signed the FL2 which listed 10 units of Humalog as his current insulin dose. -He thought the PCP and the pharmacy considered medications on the FL2 as orders. -Resident #1's PCP never provided him with a sliding scale for administering the Humalog. -Whenever Resident #1 went to the PCP, staff were instructed to "keep doing what we are doing". -He was not notified of an order written on 06/16/20 because he was "never" notified when the PCP sent e-prescriptions to the pharmacy.	C 330		

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C 330	Continued From page 11 -When he received the July 2020 MAR the Humalog was listed as 3-13 units three times a day per sliding scale so he contacted the pharmacy to see why it was listed that way. -The pharmacy said the PCP should send a sliding scale and since he did not receive a sliding scale from the PCP he assumed it was a misprint so he continued to administer 10 units of Humalog three times a day as was listed on the FL2 dated 06/09/20. -He continued to assume the 3-13 units Humalog entry was a misprint on all MARs from August 2020 through February 2021, never clarified with the pharmacy or the PCP and continued to administer 10 units of Humalog, three times a day. -The Administrator again took Resident #1 to the PCP on 02/09/21 and had the current FL2 signed at that appointment. -When he received the March 2021 and April 2021 MAR the Humalog was still entered as 3-13 units per sliding scale and again he did not clarify the order with the PCP or the pharmacy but continued to administer 10 units three times a day. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/20/21 at 10:03am revealed: -Resident #1 had an order for 10 units of Humalog, three times a day, from 04/03/19 until 06/16/20 when it was changed to 3-13 units per sliding scale, three times a day with a max dose of 39 units. -Resident #1's Primary Care Physician (PCP) "always" sent e-prescriptions for medication orders. -The pharmacy did not have what the sliding scale order was; the PCP would have given that to the facility.	C 330		

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C 330	Continued From page 12 -They received another e-prescription on 12/14/20 for 3-13 units and dispensed it on 02/01/21, 03/03/21 and 04/02/21. -She was unaware the facility was administering 10 units three times a day, rather than using a sliding scale. -The pharmacy received a copy of Resident #1's FL2 dated 02/09/21 but they did not accept medications listed on it as orders. -The pharmacy printed all MARs for the facility. Interview with Resident #1's PCP on 04/20/21 at 11:09am revealed: -Resident #1 was seen at his office on 06/16/20 and was changed to sliding scale Humalog at that appointment. -The sliding scale Humalog was discussed with the facility staff who accompanied him on the visit, according to his notes. -He thought the facility had a copy of the sliding scale insulin orders and for clarification he would fax a copy over to the facility at that time. -He did not know that Resident #1 was receiving 10 units of insulin 3 times a day instead of sliding scale insulin as ordered. -Resident #1 was seen again in his office on 02/09/21 and according to his notes the sliding scale Humalog order was again discussed with staff. -He signed a FL2 on 02/09/21 but thought of the FL2 as a review of medications and not an actual order. -Orders for Humalog were always sent to the pharmacy as an e-prescription. -The most recent prescription he wrote for sliding scale Humalog was on 03/03/21 and he only sent it to the pharmacy as there was no office visit with Resident #1 on that day. -He wanted Resident #1 to receive Humalog based upon his blood sugar level because his	C 330		

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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 330	Continued From page 13	C 330		

blood sugars were typically high.
-Depending upon what his blood sugar level was, administering ten units of Humalog three times a day may be too much Humalog and that could cause him to have dangerously low blood sugar.

Review of Sliding Scale Insulin (SSI) orders faxed from Resident #1's PCP's on 04/20/21 revealed:
-Use Humalog KwikPen (U100) 100units/mL, subcutaneous with a maximum dose of 39 units per day.
-Administer 3 units for FSBS of 150-200.
-Administer 5 units for FSBS of 200-250.
-Administer 7 units for FSBS of 251-300.
-Administer 9 units for FSBS of 300-350.
-Administer 11 units for FSBS of 351-400.
-Administer 13 units for FSBS of >400.

Interview with the Facility Manager on 04/20/21 at 1:17pm revealed:
-He "normally" sent a paper with staff when they took residents to the PCP's office so the PCP could write out any instructions or communicate any changes.
-He did not have any paperwork from appointments other than the signed FL2's.

Interview with the Supervisor-in-Charge (SIC) on 04/20/21 at 2:09pm revealed:
-She started working at the facility about a month ago.
-When the Facility Manager trained her she had been instructed to administer 10 units of Humalog three times a day to Resident #1, even though the MAR entry was written to give 3-13 units per sliding scale, three times a day.
-She administered 10 units of Humalog at 8:00am, 12:00 noon and 4:00pm to Resident #1.

Interview with the Administrator on 04/20/21 at

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C 330	Continued From page 14 1:17pm revealed: -He did not remember if he took Resident #1 to his PCP appointments but if the Facility Manager said he did, he "probably" did. -If he took papers to the PCP for a signature he would bring them back to the facility and give them to the Facility Manager. -He did not remember if he returned papers from Resident #1's PCP appointments. -He did not recall any conversations about insulin/Humalog at Resident #1's PCP appointments. -The Facility Manager was responsible for maintaining all resident paperwork and orders. _____ The facility failed to ensure Humalog insulin was administered as ordered, resulting in Resident #1 receiving more insulin than was ordered for 306 times out of 313 insulin administrations putting him at risk of experiencing low blood sugar which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/20/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 4, 2021.	C 330		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's	C 367		

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C 367	Continued From page 15 record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the record of controlled substances was maintained and reconciled accurately for 2 of 2 sampled residents (Residents #1 and #2) with orders for pain medication (#1) and anti-anxiety medication (#2). The findings are: 1. Review of Resident #2's current FL2 dated 03/03/21 revealed: -Diagnoses included dementia, chronic schizophrenia, irritable bowel syndrome, urinary incontinence, and seizure disorder. -There was an order for lorazepam (used to treat anxiety) 1mg 1 tablet three times a day. Observation of Resident #2's medications on hand 04/20/21 at 9:50am revealed: -The oral medications were packaged in multidose packaging. -The multidose packaging consisted of a large roll of small plastic bags of medications sectioned off into specific administration times and stored in a cardboard box. -The lorazepam 1mg tablets were included in Resident #2's multidose packaging with the resident's other oral medications. Observation of Resident #2's available lorazepam 1mg tablets on 04/20/21 at 1:25pm revealed there were 35 lorazepam 1mg tablets available in the multidose packaging. Review of Resident #2's Medication	C 367		

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C 367	Continued From page 16 Administration Record (MAR) dated 02/08/21 to 03/07/21 revealed: -There was an entry for lorazepam 1mg 1 tablet three times a day scheduled for 8:00am, 4:00pm, and 8:00pm with an ordered date of 12/07/20. -The lorazepam was documented as administered three times daily from 02/08/21 to 03/07/21. Review of Resident #2's MAR dated 03/08/21 to 04/07/21 revealed: -There was an entry for lorazepam 1mg 1 tablet three times a day scheduled for 8:00am, 4:00pm, and 8:00pm with an ordered date of 12/07/20. -The lorazepam was documented as administered three times daily from 03/08/21 to 04/07/21. Review of Resident #2's MAR dated 04/05/21 to 05/04/21 revealed: -There was an entry for lorazepam 1mg 1 tablet three times a day scheduled for 8:00am, 4:00pm, and 8:00pm with an ordered date of 04/01/21. -The lorazepam was documented as administered three times daily from 04/05/21 to 04/20/21 at 8:00am. Review of Resident #2's Controlled Substance Count Sheet (CSCS) dated 04/18/21 to 04/20/21 revealed: -The CSCS was for lorazepam 1mg tablets. -The starting quantity was 42 tablets. -The sheet was started on 04/18/21 at 8:00pm. -The last entry was dated 04/20/21 at 8:00am. -The amount left was documented as 37 tablets. Telephone interview with a pharmacist from the contracted pharmacy on 04/20/21 at 1:16pm revealed: -They had dispensed 84 tablets of lorazepam	C 367		

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C 367	Continued From page 17 1mg tablets for Resident #2 on 03/03/21 and on 03/28/21. -The 84 tablets of lorazepam was a 28-day supply of the medication. Interview with the Facility Manager on 04/20/21 at 1:27pm revealed: -They had begun administering the current cycle of multidose medication packs to Resident #2 on 04/01/21, which included the resident's lorazepam supply. -He did not know he was supposed to keep CSCS sheets for controlled substances included in multidose packaging. -He had started a CSCS sheet for Resident #2's lorazepam on 04/18/21, after being found non-complaint with the same issue in a sister-facility. -He had counted all the lorazepam tablets inside the multidose packages on 04/18/21 and to come up with 42 tablets of lorazepam 1mg. -He must have made an inaccurate count of the tablets on 04/18/21, because there were lorazepam tablets available for all scheduled administration times in the multidose packaging. -There were no additional CSCS sheets for Resident #2's lorazepam other than the one started on 04/18/21. Attempted telephone interview with the Administrator on 04/20/21 at 2:25pm was unsuccessful. 2. Review of Resident #1's current FL2 dated 02/09/21 revealed: -Diagnoses included hypertension, diabetes, depression, seizure disorder, and intellectual disability. -There was an order for tramadol HCL 50mg, 1 tablet twice a day.	C 367		

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C 367	Continued From page 18 Review of Resident #1's Medication Administration Record (MAR) dated 02/08/21 through 03/07/21 revealed there was an entry for Tramadol HCL 50mg, 1 tablet two times a day and documented as administered two times a day from 02/08/21 through 03/07/21. Review of Resident #1's MAR dated 03/08/21 through 04/07/21 revealed: -There was an entry for Tramadol HCL 50mg, 1 tablet two times a day and documented as administered two times a day from 03/08/21 through 04/02/21 and 04/05/21 through 04/06/21. -Tramadol was documented as administered 3 times a day on 04/03/21 and 04/04/21. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed there was an entry for Tramadol HCL 50mg, 1 tablet two times a day and documented as administered two times a day from 04/05/21 through 04/19/21 and at 8:00am on 04/20/21. Review of Resident #1's Controlled Substance Count Sheet (CSCS) revealed: -The CSCS was started on 04/18/21 for Tramadol HCL 50mg. -The beginning quantity was documented as 23 tablets. -Tramadol was documented as administered at 8:00pm on 04/18/21, at 8:00am and 8:00pm on 04/19/21 and at 8:00am on 04/20/21. -The ending quantity was documented as 19 tablets. Observation of Resident #1's medication available for administration on 04/20/21 at 10:52am revealed: -Tramadol HCL 50mg was available for	C 367		

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C 367	Continued From page 19 administration. -Tramadol 50mg was packaged with his other medications in a multi-pack. -There were 19 pills available for administration. Interview with the Manager on 04/20/21 at 1:38pm revealed: -The multi-packs of medication were sent to the facility as a 28 day supply. -On 04/14/21 he became aware of the requirement to maintain a CSCS for controlled medications packaged in a multi-pack. -He started a CSCS for Resident #1's tramadol HCL 50mg on 04/18/21 and started documenting administration at 8:00pm. -Resident #1's MAR dated 04/05/21 through 05/04/21 and medication multi-pack was delivered to the facility at the end of March 2021 and he started administering medications out of it on 03/31/21. -He had administered 41 of the 56 available Tramadol HCL out of the multi-pack which meant that he should have 15 tablets left in the multi-pack. -He did not know why there were 19 tabletss left in the multi-pack and documented as available per the CSCS.	C 367		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews, the	C 912		

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C 912	Continued From page 20 facility failed to ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration. The findings are: Based on interviews, and record reviews, the facility failed to administer a medication as ordered by the licensed prescribing practitioner and in accordance with the facility's policy for 1 of 3 sampled residents (#1) related to a fast-acting insulin.[Refer to Tag 0330, 10A NCAC 13G .1004(a) Medication Administration. (Type B Violation)].	C 912		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to	C992		

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C992	Continued From page 21 the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had completed an examination and screening for the presence of controlled substances upon hire. The findings are: Review of Staff A's personnel record revealed: -There was a hire date of 02/20/20. -There was a photocopy of a test cup with test results on the side. -The photocopy had a handwritten date of 02/20/20 and Staff A's name. -There was no interpretation of the test result available. -There was no list of substances that had been included in the test. Interview with Staff A, Supervisor-In-Charge (SIC), on 04/20/21 at 2:15pm revealed: -The drug test she had taken on 02/20/20 was a urine drug test purchased at a local discount	C992		

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C992	Continued From page 22 store. -She did not know how many and what drugs were screened for in the test. Interview with the Facility Manager on 04/20/21 at 11:10am revealed: -The service they normally used to do drug testing for new hires had been "backed up" when it had been time to complete a drug test for Staff A. -He purchased a drug test from a local discount store to use to drug test Staff A. -He had thrown away the box and instructions from the drug test he used to test Staff A. -He did not know how many and what drugs were screened in the test. Attempted telephone interview with the Administrator on 04/20/21 at 2:25pm was unsuccessful.	C992		