

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 07/14/2021
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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 13, 2021 to July 14, 2021.	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 substantiated 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 interviews, the facility failed to ensure 1 of 3 staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of personnel record's revealed there was no personnel record for Staff A. Interview's with the Administrator on 07/14/21 at 11:45am and at 1:00pm revealed: -He could not locate the personnel record for Staff A. -He could not locate the HCPR check for Staff A. -He did not know how long Staff A had been employed. -Staff A was a medication aide (MA). -The Assistant Administrator was responsible for maintaining the personnel records. -The Assistant Administrator should have verified the HCPR on Staff A upon hire.	C 145		

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

TITLE

(X6) DATE

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C 145	Continued From page 1 The Assistant Administant Administrator was unavailable for interview on 07/14/21.	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 in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 direct care staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of personnel records revealed there was no personnel record for Staff A. Interviews with the Administrator on 07/14/21 at 11:45am and at 1:00pm revealed: -He could not locate the personnel record for Staff A. -He could not locate the criminal background check for Staff A. -He did not know how long Staff A had been employed. -Staff A was a medication aide (MA). -The Assistant Administrator was responsible for maintaining the personnel records. -The Assistant Administrator should have verified the criminal background on Staff A upon hire. The Assistant Administant Administrator was	C 147		

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C 147	Continued From page 2 unavailable for interview on 07/14/21.	C 147		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure follow up for 1 of 3 residents sampled (#1) for an ankle fracture after the resident fell. The findings are: Observation of Resident #2 on 07/13/21 at 8:00am revealed: -Resident #2 had a cast on her left foot and was using a walker to ambulate. -She had on a hospital wrist band dated 07/12/21. Review of Resident #2's discharge documents from the local hospital dated 07/12/21 revealed: -Resident #2 was seen in the emergency room for ankle pain. -Resident #2 had x-rays completed on 07/12/21 but left the hospital before the x-ray results were read by the hospital physician. Interview with Resident #2 on 07/13/21 at 8:27am and 9:47am revealed: -She fell outside on the side porch in the facility's smoking area on Friday, (07/09/21). -She hurt her ankle when she fell. -There were no staff outside at the time of her	C 246		

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C 246	Continued From page 3 fall; two other residents witnessed her fall and one resident helped her to her feet. -The resident that helped her to her feet went inside and told the medication aide (MA) about her fall. -The MA did not offer to send her to the hospital; the MA "basically did nothing". -Her foot felt "mushy" inside. -She had swelling and pain in her foot over the weekend. -She tried not to walk after she fell because her foot hurt when she walked. -She did not tell the staff about her foot hurting because they would not do anything anyway and she did not want to bother them. -She went to the hospital on Monday, (07/12/21) when a different MA noticed her foot was swollen. -The staff at the hospital said her foot was "split". Interview with a resident on 07/13/21 at 9:47am revealed: -She and another resident witnessed Resident #2 fall in the smoking area on Friday, (07/09/21) in the afternoon. -Resident #2 was "just walking" and fell. -She helped Resident #2 stand up by helping her pull herself up on a chair and then turn around and sit in the chair. -She told the MA right away that Resident #2 fell. -The MA came outside but Resident #2 was in the chair by then. -The MA asked Resident #2 if she was okay. -The MA did not ask Resident #2 if she wanted to go to the hospital. Interview with a second resident on 07/13/21 at 9:47am revealed: -She had witnessed Resident #2 fall on Friday, (07/09/21) after lunch sometime. -Another resident told the MA that Resident #2	C 246			

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C 246	Continued From page 4 fell. -The MA came outside and asked Resident #2 if she was "alright". -The MA did nothing else and did not offer to send Resident #2 to the hospital. Telephone interview with Resident #2's primary care provider (PCP) on 07/14/21 at 12:32pm revealed she was notified by staff from the facility that Resident #2 was sent to the hospital and had a fracture on the day the resident went to the hospital, (07/12/21). Interview with a MA 07/13/21 at 9:14am and 11:27am revealed: -She began her three-day shift on Saturday 07/10/21 at about 8:00am. -Resident #2 told her on Sunday, (07/11/21) that she fell the week before; she did not know the exact date Resident #2 fell. -Resident #2 complained of foot pain on Sunday, (07/11/21) so she elevated the resident's foot. -Resident #2 said the pain got better after her foot was elevated. -She noticed Resident #2's foot was swollen and discolored on Monday, (07/12/21) and she "did not like the way it looked". -She called the Supervisor-in-Charge (SIC) that was filling in for the Assistant to the Administrator and informed her about Resident #2's foot because the resident had diabetes. -Resident #2 was transported by ambulance to the local hospital on 07/12/21. -Resident #2 returned from the local hospital the same day. -The staff that brought her back to the facility said Resident #2 had a sprained ankle. Interview with the MA on shift when Resident #2 fell on 07/14/21 at 9:50am revealed:	C 246			

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C 246	Continued From page 5 -She did not know what happened on Friday, (07/09/21) because Resident #2 did not tell her about a fall. -She did not see Resident #2 fall, and no one told her Resident #2 had fallen on 07/09/21. -A resident told her Resident #2 fell but that was "way before 07/09/21"; she thought it was about two days before 07/09/21. -She checked on Resident #2 when another resident said Resident #2 fell; Resident #2 said she was "alright". -Resident #2 said she did not want to go to the hospital; Resident #2 seemed okay. -She watched Resident #2 walk around for about three days after she was told about a fall and she did not "limp". -She was supposed to call for emergency medical services (EMS) when a resident fell but Resident #2 was alright, so she did not call EMS. -She did not check Resident #2's vitals when she fell because the resident was talking okay and was not breathing too hard; she checked Resident #2's legs and feet for bruising. -She checked on Resident #2 in the evening on Friday, (07/09/21) and she was fine; Resident #2 did not complain of pain. -The last time she saw Resident #2 was about 9:30am on 07/10/21 and she was not limping. -She found out Resident #2 had a fractured foot when she came to work in the evening on 07/13/21. Interview with the SIC on 07/13/21 at 9:30am and 9:45am revealed: -She worked as the SIC at a sister facility and did not work in the facility except to help or relieve staff. -She was filling in for the Assistant to the Administrator. -She was told on 07/12/21 by the MA that	C 246		

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C 246	Continued From page 6 Resident #2's foot was swollen, discolored, and the resident was complaining of pain. -The MA wanted to send Resident #2 to the local hospital's emergency department, and she agreed to send the resident to the hospital. -Resident #2 told the MA on 07/12/21 that she fell sometime the week before; the MA also told her Resident #2 said she did not want to go to the hospital when she fell. -She was not made aware Resident #2 fell sometime the week before until 07/12/21. -She did not know the exact date the resident fell or who the staff was that was working when Resident #2 fell. -The facility policy was to send the residents to the hospital if they fell and to notify the SIC and the Administrator. -She could not find out what staff was working the week before when Resident #2 fell. -She could not determine if Resident #2 refused to go to the hospital when she fell. -Staff may not have reported Resident #2's fall to the Administrator or to her because they may not have seen Resident #2 fall. -If Resident #2 did not report the fall to the MA working on the day she fell then the MA may not have known Resident #2 even fell. Second interview with the SIC on 07/14/21 at 9:39am revealed: -Resident #2 left the hospital on 07/12/21 before the results of her x-ray were completed. -A representative from the local hospital called her on 07/12/21 and told her Resident #2 had a small fracture in her ankle. -The representative from the hospital requested Resident #2 come back to the hospital for a different cast due to a hairline fracture on her foot. -The facility did not have a copy of any	C 246		

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C 246	Continued From page 7 documents from the hospital concerning Resident #2's fracture. Interview with the Administrator on 07/14/21 at 10:07am revealed: -Staff were to notify the SIC when there was a fall or a reported fall. -The SIC would notify him and he would call EMS. -The MAs did not perform assessments on residents because they were not qualified to make a medical assessment. -EMS were supposed to be called so they could perform the assessment on a resident and decide what should be done after a fall. -He was not made aware of any resident falls prior to 07/12/21. -The MA that was working on 07/12/21 noticed Resident #2 was limping, and she called the SIC. -He was not sure when the SIC was made aware of Resident #2's foot, but he knew she made the decision to call EMS for Resident #2. -The SIC notified him by telephone after Resident #2 was transported to the local hospital by EMS on 07/12/21. _____ The facility failed to follow up for three days after a resident fell and fractured her foot, while the resident continued to walk with the fractured foot and suffered swelling, discoloration, and pain. The failure 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 July 13, 2021 for this violation.	C 246			

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C 246	Continued From page 8 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 28, 2021	C 246		
C 260	10A NCAC 13G .0904 (b-1) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Food Preparation and Service in Family Care Homes: (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the freezer side of the upright refrigerator and a standalone freezer were maintained at the proper temperature range of 0 degrees Fahrenheit (F) to 10 degrees F. The findings are: Observation of the upright refrigerator on 07/13/21 at 8:06am revealed: -There was not a thermometer inside the freezer side of the upright refrigerator to indicate the freezer was at the required zero degrees Fahrenheit. -The door to the freezer would not stay closed and would open after closure. -There was a variety of food in the freezer side of the upright refrigerator that was thawed and dripping including chicken nuggets and waffles.	C 260		

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C 260	Continued From page 9 -There was water on the inside floor of the freezer side of the upright refrigerator. Observation of the standalone freezer on 07/13/21 at 8:06am revealed: -The door to the freezer was slightly ajar and would not close. -There was a puddle of water on the floor in front of the freezer. -The thermometer on the door of the freezer read 42 degrees F. -There was a variety of food on shelves in the freezer that was thawed and dripping including a 10-pound tube of ground beef on a shelf that was thawed and dripping. -There was a variety of food stored on the door that was thawed and dripping including hotdogs. Interview with the medication aide (MA) on 07/13/21 at 8:06am revealed: -She was not aware the freezer door did not close on either of the freezers. -She had opened the freezer door to the upright refrigerator that morning but did not notice any thawed food or that the waffles she got out for breakfast today were not frozen. -She did not check temperatures of the freezers when she worked. -She did not know how long the doors to the freezers had been open. Interview with the Administrator on 07/13/21 at 9:40am revealed: -He was made aware of the two freezers being thawed that morning by the MA after 8:00am. -The doors to both freezers would have to be repaired so they would close again and form a seal. -He had no idea the freezers had been open, but it must have been a long time for all the food to	C 260		

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C 260	Continued From page 10 thaw. -He would have to go through the food in the freezer and decide what to keep and what to discard. -He was not aware there was not a thermometer in the freezer side of the upright refrigerator. -Staff were not required to routinely monitor the temperatures of the freezers and refrigerator unless an issue had been discovered and there was a reason.	C 260		
C 273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 8 ounces of milk was offered or served to the residents twice daily. The findings are: Observation of the refrigerator on 07/13/21 at 8:00am revealed there was no milk available for serving to the residents.	C 273		

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C 273	Continued From page 11 Observation of the seven-day week-at-glance menu provided by the facility on 07/13/21 revealed one cup of two percent milk was to be served with the breakfast meal and a half a cup of two percent milk was to be served at lunch and dinner. Observation of the lunch meal service on 07/13/21 at 12:11pm revealed the residents were not offered or served milk. Interview with three residents on 07/13/21 at 8:30am revealed: -The got milk when they had cereal. -They would like milk to drink; it depended on what they were eating. -They thought they had milked a few days ago. Interview with the medication aide (MA) on 07/13/21 at 9:05am revealed: -There were four residents that resided in the facility. -She had started her shift for work on Saturday, 07/10/21 at 8:00am and there had not been any milk at the facility since then. -She did not offer milk to the residents; if she had milk to offer, she would have served it. -The Supervisor-in-Charge (SIC) from a sister facility had brought groceries the day before but she did not bring milk. -She could tell the SIC from the sister facility she needed milk, but she had not thought about it. Interview with the Administrator on 07/14/21 at 11:31am revealed: -Milk should have been offered to the residents at every meal. -There should have been milk at the facility to serve to the residents. -Milk could have been brought to the facility from	C 273		

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C 273	Continued From page 12 the sister facility if the MA had let him or the SIC from the sister facility know. -The staff were responsible for informing him or the SIC that they needed milk. -He did not check the facility for milk; that was the responsibility of the SIC. -He expected the menu to be followed.	C 273		
C 274	10A NCAC 13G .0904(d)(3)(B) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure fruit was served twice daily to residents including a serving of citrus juice or fruit. The findings are: Observation of the refrigerator on 07/13/21 at 8:00am revealed there was no citrus juice or juice available for serving to the residents. Observation of the food storage room on 07/13/21 at 8:00am revealed there was no	C 274		

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C 274	Continued From page 13 canned fruit or juice available for serving to the residents. Observation of the seven-day week-at-glance menu provided by the facility on 07/13/21 revealed a half cup of grapefruit sections was to be served with the breakfast meal, a half a cup of peaches was to be served at the lunch meal and a half a cup of fruit cocktail was to be served the dinner meal. Observation of the lunch meal service on 07/13/21 at 12:11pm revealed the residents were not served fruit but were served a cookie or pudding. Interview with three residents on 07/13/21 at 8:30am revealed: -They would like to have fruit. -They would like to drink orange juice with the breakfast meal; one of the residents had acid reflux so she would like apple juice instead of orange juice. -They would like fresh fruit like watermelon. -They could not remember the last time they had fruit; they thought it was a week ago. Interview with the medication aide (MA) on 07/13/21 at 9:05am revealed: -She had started her shift for work on Saturday, 07/10/21 at 8:00am and there had not been any fruit or fruit juice at the facility since then. -She would have served fruit to the residents if it had been available to serve to them. -She followed the menu and served what the residents liked; the residents liked fruit and would eat it when she served it. -The Supervisor-in-Charge (SIC) from a sister facility had brought groceries the day before but she did not bring fruit or citrus juice.	C 274		

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C 274	Continued From page 14 -She could tell the SIC from the sister facility she needed fruit and fruit juice, but she had not thought about it. Interview with the Administrator on 07/14/21 at 11:31am revealed: -Fruit should be served to the residents at daily according to the menu; orange juice or apple juice should have been served at the breakfast meal. -There should have been fruit and fruit juice at the facility to serve to the residents. -Fruit juice and canned fruit could have been brought to the facility from the sister facility if the MA had let him or the SIC from the sister facility know. -The staff were responsible for informing him or the SIC that they needed any groceries.	C 274		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: :Based on observations, record review and interviews, the facility failed to maintain an accurate therapeutic diet list for guidance of food service staff for 1 of 3 residents sampled (#1) who had an order for mechanical soft diet. Review of Resident #3's current FL-2 dated 05/26/21 revealed:	C 284		

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C 284	Continued From page 15 -Diagnoses included adjustment disorder with mixed disturbance of emotions and conduct, bipolar affective disorder-mixed severe, aggression, vitamin b deficiency, moderate intellectual disability. -There was an order for no concentrated sweets (NCS), mechanical soft diet. Observation on 07/13/21 at 9:05am revealed Resident #1 was documented on the therapeutic diet list for a NCS diet. Observation of Resident #1 during lunch on 07/13/21 at 12:00pm revealed: -She had a tuna salad sandwich, carrots, ½ banana, sugar free pudding, tea and water. -She consumed all food except the carrots. -She did not have problems chewing or swallowing her food during lunch. Interview with the medication aide (MA) on 07/13/21 at 9:21am revealed: -There were no residents on therapeutic diets. -She followed the regular menu and prepared what the residents liked. -She did not know Resident #1 was on a mechanical soft diet. -She did not refer to the posted therapeutic diet list. -She prepared waffles with syrup, apple juice and water this morning for breakfast. Interview with a second MA on 07/14/21 at 8:30am revealed: -She thought all residents were on regular diets. -The therapeutic diet list was posted on the kitchen wall. -She had referred to the therapeutic diet list. -She would check the therapeutic diet list when she returned to work after being off several days.	C 284			

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C 284	Continued From page 16 -She did not know who prepared the therapeutic diet list. -She was not aware that Resident #1 had an order for mechanical soft diet. -She did not know why Resident #1 was on mechanical soft diet. Interview with the Administrator on 07/14/21 at 11:36am revealed: -The staff should reference the therapeutic diet list. -He was responsible for updating the therapeutic diet list. -The staff would let him know when there was a change in a diet order. -He did not know Resident #3 had an order for mechanical soft diet.	C 284		
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 observations, interviews and record reviews the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #2) related to a medication	C 330		

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C 330	Continued From page 17 used to treat the symptoms of type II diabetes mellitus, a medication used to treat muscle spasms as a side effect of other medications, and a bronchodilator used to control symptoms of chronic obstructive pulmonary disease (COPD). The findings are: Review of Resident #2's current FL-2 dated 04/15/21 revealed diagnoses included tardive dyskinesia, depression, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism, and history of cerebrovascular accident. Review of Resident #2's hospital discharge documents revealed she had been admitted to the hospital on 06/14/21 and discharged on 06/18/21 and readmitted on 06/18/21 and discharged on 06/23/21. a. Review of Resident #2's current FL-2 dated 04/15/21 revealed there was an order for Levemir 100unit/mL (used to treat the symptoms of type II diabetes mellitus) inject 20 units twice daily. Review of Resident #2's six month signed physician's order dated 05/17/21 revealed an order for Levemir 100units/mL inject 20 units subcutaneously twice daily. Review of Resident #2's May 2021 medication administration record (MAR) revealed: -There was an entry for Levemir 100units/mL inject 20 units subcutaneously twice daily scheduled at 8:00am and 5:00pm. -There were no parameters for Resident #2's Levemir injections. -There was documentation Resident #2 refused the Levemir at 4:00pm on 05/09/21, 05/10/21,	C 330		

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C 330	Continued From page 18 05/11/21 and 05/14/21. -Levemir was documented as administered 58 out of 62 opportunities from 05/01/21 to 05/31/21 at 8:00am and 5:00pm daily. Review of Resident #2's June 2021 MAR revealed: -There was an entry for Levemir 100units/mL inject 20 units subcutaneously twice daily scheduled at 8:00am and 5:00pm. -There were no parameters for Resident #2's Levemir injections. -There was no documentation Resident #2 was out of the facility on 06/14/21 to 06/23/21. -Levemir was documented as administered 60 out of 60 opportunities from 06/01/21 to 06/30/21 at 8:00am and 5:00pm daily. Review of Resident #2's July 2021 MAR revealed: -There was an entry for Levemir 100units/mL inject 20 units subcutaneously twice daily scheduled at 8:00am and 5:00pm. -There were no parameters for Resident #2's Levemir injections. -Levemir was documented as administered 21 out of 25 opportunities from 07/01/21 to 07/13/21 at 8:00am and 5:00pm daily. Observation of Resident #2's medication on hand on 07/13/21 at 3:43pm revealed: -There was a box labeled Levemir 100units/mL pen with an order to inject 20 units twice daily. -The dispense date on the box of Levemir pens was 05/19/21; five 15mL pens were dispensed in the box. -There was one Levemir pen that was set at zero and the pen contained the full 15mL; there were no other pens available for administration. Telephone interview with a pharmacist from the	C 330		

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C 330	Continued From page 19 facility's contracted pharmacy on 07/13/21 at 5:59pm revealed: -Resident #2 had a current order for Levemir inject 20 units twice daily. -One box of Levemir 100 units/mL with five pens per box was dispensed on 01/12/21, 03/16/21 and 05/19/21. -Resident #2's Levemir was not on a cycle fill refill and had to be requested by the facility when needed. -One box of Levemir would have lasted Resident #2 for 45 days. -Levemir was used to lower blood glucose levels. -Possible outcomes of not receiving Levemir as ordered could be hyperglycemia; long term hyperglycemia could cause vision problems, cardiovascular disease, kidney and other organ damage and nerve damage. Telephone interview with Resident #2's primary care provider (PCP) on 07/14/21 at 12:22pm revealed: -She did not recall Resident #2's Levemir order but expected the facility to follow the order according to the MAR. -Resident #2's last blood glucose A1c (an A1c test is a blood test that reflects the average blood glucose level over the past 3 months) was 7 percent (a normal A1C level is below 5.7 percent) in March 2021. Interview with Resident #2 on 07/13/21 at 8:30am revealed: -She got an injection if she "needed it" for her diabetes. -She got an injection twice daily but only if her "sugar" [finger stick blood sugar (FSBS)] results were high; she did not get her injection every day. -She had an injection that morning because her FSBS was over 400.	C 330		

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C 330	Continued From page 20 Interview with a medication aide (MA) on 07/13/21 at 9:24am and 1:14pm revealed: -Resident #2 had FSBS scheduled twice daily and she received an injection when her FSBS results were above 135. -Resident #2 was not administered her Levemir twice daily and was not administered her Levemir everyday. -She did not reference the MAR when she administered medication. Interview with a second MA on 07/14/21 at 8:26am revealed: -Resident #2 was a diabetic and had FSBS checks twice daily. -Resident #2 was not administered a Levemir injection when her FSBS was "too low"; anything below 53 was too low. -Resident #2 had an order for Levemir injections when her FSBS results were "too high"; FSBS above 135 was high. -She had been told by another MA to only administer the Levemir when Resident #2's FSBS was above 135. -She presumed the Supervisor-in-Charge (SIC) had talked to Resident #2's PCP and that was where the FSBS of 135 came from. -She thought the parameters for the Levemir injections were on the MAR. -She did not always reference the MAR when she administered medications. Interview with the Administrator on 07/14/21 at 10:35am revealed: -He expected the staff to administer medication as ordered on the MAR. -The MAs could not decide when to give a medication or when to hold a medication; they should be following the orders on the MAR.	C 330		

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C 330	Continued From page 21 -The MAs were not to strictly follow the orders on the box of Levemir but to reference the MAR for the order and compare the two orders. -He was not familiar with Resident #2's medication; he referenced the MAR to see an order. -The Levemir should have run out and been reordered based on the dispense date and the current order. b. Review of Resident #2's current FL-2 dated 04/15/21 revealed there was an order for benzotropine mesylate (used to treat muscle spasms as a side effect from other medications) 1mg once daily. Review of Resident #2's six month signed physician's order dated 05/17/21 revealed an order for benzotropine mesylate 1mg twice daily. Review of Resident #2's hospital discharge paperwork dated 06/18/21 revealed benzotropine mesylate 1mg twice daily was discontinued. Review of Resident #2's medication administration record (MAR) for June 2021 and July 2021 revealed: -There was an entry for benzotropine mesylate 1mg twice daily scheduled at 8:00am and 8:00pm. -Benzotropine mesylate 1mg was documented as administered twice daily 24 of 24 opportunities from 06/23/21 to 06/30/21. -Benzotropine mesylate 1mg was documented as administered twice daily 24 of 26 opportunities from 07/01/21 to 07/13/21. Observation of Resident #2's medication on hand on 07/13/21 at 3:43pm revealed:	C 330			

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C 330	Continued From page 22 -There was a medication cards with multiple medications packaged together in one bubble. -There was a medication card for benztropine mesylate the 8:00am administration time and a second card for the 8:00pm administration time. -The back of each card had a picture of the medication and the medication order; benztropine mesylate 1mg twice daily. -The back of each bubble had the medication name, strength, dosage and date. -The 8:00pm dose dated 07/13/21 and the 8:00am dose dated 07/14/21 were available for administered. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/13/21 at 5:21pm revealed: -The pharmacy cycle filled the benztropine mesylate 1mg on 06/29/21. -The pharmacy received the discontinue order for the benztropine mesylate via facsimile from the facility on 07/01/21. -The benztropine mesylate 1mg had been discontinued on 06/18/21 by the hospital on the document the facility faxed on 07/01/21. -The benztropine mesylate had already been dispensed when the pharmacy received the discontinue order. -The facility should have contacted the pharmacy and sent the discontinued medication back for repackaging when they received it. -The hospital had discontinued the benztropine mesylate because they had replaced the benztropine mesylate with a new medication and the new medication should not have been administered in combination with the benztropine. -The possible outcome of administering both medications to Resident #2 would be extreme dry mouth.	C 330		

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C 330	Continued From page 23 Telephone interview with Resident #2's primary care provider (PCP) on 07/14/21 at 12:22pm revealed: -She did not discontinue Resident #2's benztropine mesylate. -Resident #2 was admitted to the hospital in June 2021 for a mental health evaluation; the hospital had discontinued the benztropine mesylate and replaced it with a new medication. -The benztropine mesylate should have been stopped when the hospital discontinued it. Interview with Resident #2 on 07/13/21 at 8:30am revealed she did not know what medications she took other than her diabetic medication. Interview with a medication aide (MA) on 07/13/21 at 9:24am and 1:14pm revealed: -She did not read the discharge documents that came from the hospital; she let the next MA file them in the residents' records. -She did not send discontinued medication orders to the pharmacy; the Supervisor-in-Charge (SIC) was responsible for notifying the pharmacy of order changes. -If she noticed a discrepancy on the MAR compared to a medication label then she would contact the SIC. -She did not know Resident #2's benztropine mesylate had been discontinued so she continued to administer it. Interview with the Administrator on 07/14/21 at 10:22am revealed: -The SIC was responsible for the discharge paperwork from the hospital and faxing any changes in medication orders to the pharmacy. -The SIC was responsible for checking the medication for accuracy when it arrived every month from the pharmacy.	C 330		

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C 330	Continued From page 24 -The SIC checked the orders on the medication cards with the orders on the MAR and any order changes before giving them to the MA for administering. -If there was a discrepancy with the medication or the MAR then the SIC was responsible for contacting the pharmacy for an updated MAR or to return the medication to the pharmacy for repackaging if necessary. -If there was a change in a medication order or a discontinued medication the SIC was responsible for communicating the changes verbally with the MAs. -The SIC should have checked Resident #2's medication when it was delivered, and she would have found the discontinued benzotropine mesylate. Attempted telephone interview with the SIC on 07/13/21 at 5:12pm was unsuccessful. c. Review of Resident #2's current FL-2 dated 04/15/21 revealed there was an order for a Spiriva inhaler (a bronchodilator used to control symptoms of chronic obstructive pulmonary disease (COPD)) inhale contents of 1 capsule through inhaler once daily. Review of Resident #2's six month signed physician's order dated 05/17/21 revealed an order for a Spiriva inhaler inhale the contents of 1 capsule through inhaler once daily. Review of Resident #2's May 2021 medication administration record (MAR) revealed: -There was an entry for Spiriva inhaler; inhale the contents of 1 capsule through inhaler once daily scheduled at 8:00am. -Spiriva inhaler was documented as administered once daily 31 of 31 opportunities from 05/01/21 to	C 330		

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C 330	Continued From page 25 05/31/21. Review of Resident #2's June 2021 MAR revealed: -There was an entry for Spiriva inhaler; inhale the contents of 1 capsule through inhaler once daily scheduled at 8:00am. -Spiriva inhaler was documented as administered once daily 30 of 30 opportunities from 05/01/21 to 05/31/21. Review of Resident #2's July 2021 MAR revealed: -There was an entry for Spiriva inhaler; inhale the contents of 1 capsule through inhaler once daily scheduled at 8:00am. -Spiriva inhaler was documented as administered once daily 13 of 13 opportunities from 07/01/21 to 07/13/21. Observation of Resident #2's medication on hand on 07/13/21 at 3:43pm revealed there was no Spiriva inhaler available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/13/21 at 5:21pm revealed: -There was a current order for Resident #2 for Spiriva inhaler inhale one capsule daily. -The last dispense date for Resident #2's Spiriva inhaler was 05/12/21 for a 30-day supply. -The Spiriva was not on a cycle fill and had to be ordered as needed by the facility. -Spiriva inhaler was ordered to treat symptoms of COPD and asthma. -Resident #2 could experience shortness of breath and difficulty breathing if she was not administered the inhaler as ordered. Telephone interview with Resident #2's primary care provider (PCP) on 07/14/21 at 12:22pm	C 330		

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C 330	Continued From page 26 revealed: -Resident #2 had COPD and was a smoker. -She knew Resident #2's last spirometry results were not normal. -She ordered Resident #2 the Spiriva inhaler to help her breath due to her COPD. -Resident #2 could experience shortness of breath if she was not administered the Spiriva as ordered. -She expected the facility to follow medication orders. Interview with Resident #2 on 07/13/21 at 8:30am revealed: -She did not know what medications she took other than her diabetic medication. -She used an inhaler a "while ago" but she could not remember the last time she used it. -She did have trouble breathing sometimes but it was because she smoked cigarettes not from her COPD. Interview with a medication aide (MA) on 07/13/21 at 9:24am and 1:30pm revealed: -She only administered tablets from medication cards and an injection for diabetes to Resident #2. -She had not seen an inhaler for Resident #2. -She signed the MAR after she administered the residents their medication; she did not take the book with the MARs to the medication room with her and only punched tablets from the medication cards. -She did not reorder medication from the pharmacy. -She would contact the Supervisor-in-Charge (SIC) and the SIC would contact the pharmacy to order medication refills. Interview with the Administrator on 07/14/21 at	C 330			

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 330	Continued From page 27 10:22am revealed: -The MAs were responsible for informing the SIC when an inhaler needed to be ordered from the pharmacy because they were not on a cycle fill. -The SIC was responsible for checking the medication for accuracy when it arrived every month from the pharmacy. -The SIC checked the orders on the medication with the orders on the MAR and any order changes before giving them to the MA for administering. -The SIC was responsible for ordering any medication that was not on a cycle fill; the MAs notified the SIC when they ran out of a resident's medication. -Resident #2 should not have run out of the Spiriva inhaler. Attempted telephone interview with the SIC on 07/13/21 at 5:12pm was unsuccessful. _____ The facility failed to ensure administration of medications to Resident #2 as ordered which resulted in insulin not being administered correctly which could result in the resident experiencing episodes of hyperglycemia, a medication continuing to be administered after it was discontinued which could result in extremely dry mouth, and an inhaler that was not administered which could result in shortness of breath or difficulty breathing. 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 on 07/14/21 for this violation.	C 330		

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C 330	Continued From page 28 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 28, 2021	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (Resident #2 and #3). The findings are:	C 342		

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C 342	Continued From page 29 1. Review of Resident #2's current FL-2 dated 04/15/21 revealed: -Diagnoses included tardive dyskinesia, depression, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism, and history of cerebrovascular accident. -There was an order for a Spiriva inhaler (a bronchodilator used to control symptoms of COPD) inhale contents of 1 capsule through inhaler once daily. Review of Resident #2's June 2021 medication administration record (MAR) revealed: -There was an entry for Spiriva inhaler; inhale the contents of 1 capsule through inhaler once daily scheduled at 8:00am. -Spiriva inhaler was documented as administered once daily 30 of 30 opportunities from 06/01/21 to 06/30/21. Review of Resident #2's July 2021 MAR revealed: -There was an entry for Spiriva inhaler; inhale the contents of 1 capsule through inhaler once daily scheduled at 8:00am. -Spiriva inhaler was documented as administered once daily 13 of 13 opportunities from 07/01/21 to 07/13/21. Observation of Resident #2's medication on hand on 07/13/21 at 3:43pm revealed there was no Spiriva inhaler available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/13/21 at 5:21pm revealed: -The last dispense date for Resident #2's Spiriva inhaler was 05/12/21 for a 30-day supply. -The Spiriva was not on a cycle fill and had to be	C 342		

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C 342	Continued From page 30 ordered as needed by the facility. Interview with a medication aide (MA) on 07/13/21 at 9:24am and 1:30pm revealed: -She only administered tablets from medication cards and an injection for diabetes to Resident #2. -She had not seen an inhaler for Resident #2. -She did not take the MAR with her when preparing medications for administration. -She did not compare medications administered to entries on MAR. -She signed the MAR after she administered the residents their medication. -She did not notice she had initialed the Spiriva as administered when she had not administer it. Interview with the Administrator on 07/14/21 at 10:07am revealed: -The MA should have the MAR available when preparing medication for administration. -The MA should compare medications to the MAR. -The MA should not have documented the Spiriva as administered if it was not available. -The Supervisor-in-Charge (SIC) was responsible for monthly audits of the MAR. -He did not know when the last time the MARs were audited. Attempted telephone interview with the SIC on 07/13/21 at 5:12pm was unsuccessful. 2. Review of Resident #3's current FL-2 dated 05/26/21 revealed: -Diagnoses included adjustment disorder with mixed disturbance of emotions and conduct, bipolar affective disorder-mixed severe, aggression, acute renal failure, vitamin b deficiency, tobacco use disorder, urinary tract	C 342		

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C 342	Continued From page 31 infection, moderate intellectual disability. -There was an order for aspirin (used as a blood thinner) 81mg daily. -There was an order for divalproex (used to treat mood) 500mg twice a day. -There was an order for lisinopril (used to treat high blood pressure) 10mg daily. -There was an order for quetiapine (used to treat bipolar and schizophrenia) 400mg at bedtime. -There was an order for trazodone (used for sleep and depression) 100mg three tablets at bedtime. Review of Resident #3's July 2021 medication administration record (MAR) revealed: -There was an entry for aspirin 81mg scheduled at 8:00am. -Aspirin was not documented as administered at 8:00am on 07/11/21 through 07/13/21. -There was an entry for divalproex 500mg scheduled at 8:00am and 8:00pm. -Divalproex was not documented as administered at 8:00am on 07/11/21 through 07/13/21 or at 8:00pm on 07/10/21 through 07/12/21. -There was an entry for lisinopril 10mg scheduled at 8:00am. -Lisinopril was not documented as administered at 8:00am on 07/11/21 through 07/13/21. -There was an entry for quetiapine 400mg scheduled at 8:00pm. -Quetiapine was not documented as administered at 8:00pm on 07/10/21 through 07/12/21. -There was an entry for trazodone 100mg three tablets scheduled at 8:00pm. -Trazodone was not documented as administered at 8:00pm on 07/10/21 through 07/12/21. Interview with the medication aide (MA) on 07/13/21 at 1:15pm revealed: -She signed the MAR after she administered the	C 342		

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C 342	Continued From page 32 medication. -She did not take the MAR with her when preparing medications for administration. -She did not compare medications administered to entries on MA. -She did administer the morning medications. -She did not sign the MAR from 07/10/21 at 8:00pm to 07/13/21 at 8:00am due to oversight. Interview with the Supervisor-in-Charge (SIC) on 07/13/21 at 4:34pm revealed: -The staff were to audit the MARs at the end of their shift for completion and accuracy. -The Assistant Administrator or SIC would audit the MARs monthly completion and accuracy. Interview with the Administrator on 07/14/21 at 10:07am revealed: -The MA should have the MAR available when preparing medication for administration. -The MA should compare medications to the the MAR before removing from multi-dose pack. -The MA should be documenting the medication was administered immediately after administration. -The Assistant Administrator was responsible for monthly audits of MARs for completion and accuracy.	C 342		
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 in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.	C 353		

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C 353	Continued From page 33 This Rule is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure medications were maintained in a safe manner under locked security except when not under the immediate or direct physical supervision of staff in charge of medication administration for four residents that resided in the facility. The findings are: Observation of the medication storage room on 07/13/21 at various times from 8:12am to 4:32pm revealed: -There was a room with a door that opened into the kitchen. -There was a keyed lock on the door. -The room contained shelves with multiple bins; each bin contained medication cards. -The door to the medication room was open and there was no staff in the kitchen or in the hall that lead to the kitchen. -The medication aide (MA) was in the staff room that was across the hall and one door down; the door to the medication room was not visible from the staff room. -At 8:58am a Supervisor-in-Charge (SIC) from a sister building came into the facility; she did not close the door to the medication room. -At 9:37am the Administrator and the SIC were in the office and there were no staff in the kitchen; the door to the medication room was open and the light was on inside the room. -At 4:04pm the door to the medication room was open and the Administrator, the SIC and the MA were not in the kitchen and were in another room with the door closed. -At 4:32pm the door to the medication room was	C 353		

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C 353	Continued From page 34 open and there were no staff in the kitchen; the staff were in the office. -The door to medication room could not be seen from the office. -At 4:34pm the SIC closed the door to the medication room and locked it. -There were residents in the hallway and in the kitchen where the medication room was located throughout the day. Observation of the medication storage room on 07/14/21 at 8:26am revealed: -The door to the medication room was open, the light was on and the staff was down the hall mopping the bathroom and hallway. -The door to the medication room could not be seen from the hall or the bathroom. -There was a resident walking up and down the hallway outside the kitchen where the medication room was located. Interview with the MA on 07/13/21 at 8:12am and 4:48pm revealed: -She was waiting for the next MA to come so she could leave to go home. -She had already administered the morning medications. -She had left the door unlocked because she had given the residents their cigarettes out of the room. - "I am going to lock it before I go"; she did not have a set time when the next staff would relieve her. -The door to the medication room was "always" locked when she was not around. -She always kept the keys to the medication room with her. -She would go into medication room to give the residents their cigarettes or medication and then she would lock it again.	C 353		

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C 353	Continued From page 35 Interview with the SIC on 07/13/21 at 9:21am and 4:34pm revealed: -She was the SIC from a sister facility that the Administrator owned; she helped at the current facility when the Administrator asked her too. -The medication room was always supposed to stay locked. -The door should never have been left open. Interview with the Administrator on 07/13/21 at 4:43pm revealed: -The medication room should always be closed and locked. -The only time the medication room could be unlocked was when the MA was inside getting medications to administer to residents. -He was concerned the residents could easily get to the unsecured medication.	C 353			
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 record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 1 of 1 sampled resident (Resident #2) with an order for a medication used to treat	C 367			

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C 367	Continued From page 36 insomnia and a medication used to treat anxiety. The findings are: Review of Resident #2's current FL-2 dated 04/15/21 revealed: -Diagnoses included tardive dyskinesia, depression, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism, and history of cerebrovascular accident. -There was an order for lorazepam (used to treat anxiety) 1 mg take twice daily as needed for agitation. -There was an order for zolpidem (used to treat insomnia) 5mg take at bedtime. Review of Resident #2's July 2021 medication administration record (MAR) revealed: -There was an entry for lorazepam 1mg one tablet once daily as needed for anxiety. -There was documentation lorazepam 1mg one tablet once daily was administered from five times from 07/1/21 to 07/13/21. -There was an entry for zolpidem 5mg take once daily at bedtime scheduled at 8:00pm. -There was documentation zolpidem 5mg take once daily at bedtime was administered daily from 07/1/21 to 07/13/21. Review of Resident #2's control substance count sheets (CSCS) revealed: -There was a CSCS log dispensed with Resident #2's lorazepam on 12/09/20 for 60 tablets. -There was documentation lorazepam was administered on 06/29/21 and there were 42 tablets remaining. -There was a CSCS log dispensed with Resident #2's zolpidem on 06/29/21 for 30 tablets. -There was no documentation of administration	C 367		

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C 367	Continued From page 37 on the log for Resident #2's zolpidem. Observation of Resident #2's medication on hand on 07/13/21 at 3:43pm revealed: -There was a medication card for lorazepam tablets dispensed on 12/20/20. -There were 37 lorazepam tablets available for administration. -There was a medication card for zolpidem tablets dispensed on 06/29/21. -There were 16 zolpidem tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 07/13/21 at 15:21pm revealed: -The facility was on a cycle refill system for Resident #2's zolpidem and 30 tablets were dispensed on 06/29/21. -The pharmacy included the CSCS with each dispensing. -The medication aide (MA) should document the balance of medication after each administration to track the current balance. Interview with the MA on 07/13/21 at 1:30pm revealed: -She just documented the administration of the medications on the MAR and not on the CSCS. -She knew to document the administration of the lorazepam and the zolpidem on the CSCS, but she did not. -She did not document on the CSCS because she forgot. Interview with the Administrator on 07/13/21 at 11:23am revealed: -The MA knew she was supposed to complete the CSCS sheet when administering any controlled medications, including lorazepam and	C 367		

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C 367	Continued From page 38 zolpidem. -The Supervisor-in-Charge was responsible for auditing the MAR and the CPCS, but she had been on vacation.	C 367		
C 368	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure that the controlled medication were stored under double lock for 1 of 1 sampled resident (#2) with an order for a sleeping medication and anti-anxiety medication. The findings are: Review of Resident #2's current FL-2 dated 04/15/21 revealed: -Diagnoses included tardive dyskinesia, depression, schizophrenia, hypertension, chronic obstructive pulmonary disease (COPD), hypothyroidism, and history of cerebrovascular accident. -There was an order for lorazepam (used to treat anxiety) 1 mg take twice daily as needed for agitation. -There was an order for zolpidem (used to treat insomnia) 5mg take at bedtime.	C 368		

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 368	Continued From page 39 Observation of the medication room on 07/13/21 at 3:43pm revealed: -There were plastic bins for each resident's medication sitting on an open shelf. -Resident #2's medications were all in one bin, including the lorazepam and zolpidem. -The door to the medication room had a lock but there were no other locks for the medication. Interview with the medication aide (MA) on 07/13/21 at 4:15pm revealed: -The lorazepam and zolpidem were not stored in a separate locked container. -The medication room had a lock on the door. -There had been a box to lock the controlled medication in, but the lock wore out. -She did not know the last time the controlled medication was stored in a lock box. -She thought the Administrator knew the lock box was worn out; the Supervisor-in-Charge knew the controlled storage box was worn out and told the Administrator. Interview with the Administrator on 07/14/21 at 10:59am revealed: -There was a tote box at one time for the controlled medication to be stored and locked in. -He knew controlled medication was to be kept under double locks. -All controlled medication should have been stored in the locked medication room in a separate locked tote box. -The staff should have reported to him if the lock on the box was worn out. -The last time he saw the lock box was 1 to 2 months ago. Attempted telephone interview with the SIC on 07/13/21 at 5:12pm was unsuccessful.	C 368		

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) were implemented when caring for four residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff, visitors, and residents and wearing of facemask by staff. The findings are:	C 612		

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C 612	Continued From page 41 Review of the Centers for Disease Control and Prevention (CDC) Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 03/10/21 revealed: -This guidance applies to all healthcare personnel (HCP) while at work and all patients and residents while they are being cared for in a healthcare setting. -Screen and triage everyone entering a healthcare facility for signs and symptoms of COVID-19 -Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19. -Screening for fever and symptoms should also be incorporated into daily assessments of all admitted patients. Observations upon entering the facility on 07/13/21 at 8:00am revealed: -The staff did not answer the door; a resident let the survey team into the facility and led them to the staff room. -The staff identified themselves as a medication aide (MA); the MA did not have on a mask. -The MA did not check the survey teams' temperatures or ask any screening questions. Observation of the Administrator on 07/13/21 at 9:40am revealed he did not have on a facemask and was not screened prior to entrance into the facility. Review of the facility's COVID-19 policy revealed: -There was no documentation of a screening procedure. -There were copies of various information related to COVID-19 and recommendations by the CDC.	C 612		

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C 612	Continued From page 42 Interview with three residents on 07/13/21 between 8:30am revealed: -No one had taken their temperatures at the facility. -No one asked screening questions about symptoms of COVID-19. Interview with the MA on 07/13/21 at 8:58am revealed: -She did not wear a facemask while in the facility because everyone had been vaccinated. -She thought the rules [for facemask] had changed once everyone was vaccinated. -The physician took the residents' temperatures when she came to the facility, but the MA did not take her temperature or the residents' temperatures. -She did not screen anyone for symptoms related to COVID-19 prior to entering the facility. Interview with the Administrator on 07/13/21 at 9:45am revealed: -He had screening procedures in place for visitors and staff, and he thought the staff were following them. -He did not know he needed to take the residents' temperatures daily or monitor them for symptoms of COVID-19. -He thought the staff did not need to wear a facemask anymore because they had all been vaccinated. -The staff should have taken the survey teams temperatures and screened them for symptoms.	C 612			
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:	C 912			

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C 912	Continued From page 43 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 observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration and health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure follow up for 1 of 3 residents sampled (#1) for an ankle fracture after the resident fell. [Refer to Tag 0246 Health Care 10A NCAC 13G .0902 (b) (Type B violation)]. 2. Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #2) related to a medication used to treat the symptoms of type II diabetes mellitus, a medication used to treat muscle spasms as a side effect of other medications, and a bronchodilator used to control symptoms of chronic obstructive pulmonary disease (COPD). [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	C992		

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C992	Continued From page 44 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 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 interviews and record reviews, the facility failed to ensure 2 of 3 staff (staff A and B) had no examination and screening for the presence of controlled substances completed upon hire.	C992		

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C992	Continued From page 45 The findings are: Review of personnel records on 07/04/21 revealed there was no personnel record for Staff A. Interview's with the Administrator on 07/14/21 at 11:45am and at 1:00pm revealed: -He could not locate the personnel record for Staff A. -He could not locate the controlled substance screening for Staff A. -He did not know how long Staff A had been employed. -Staff A was a MA. -The Assistant Administrator should have verified the controlled substance screening for Staff A upon hire. -The Assistant Administrator was responsible for maintaining the personnel records. The Assistant Administant Administrator was unavailable for interview on 07/14/21.	C992		