

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL043032	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/27/2016
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NAME OF PROVIDER OR SUPPLIER JOY AND DEVOTION FAMILY SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 10183 HWY 210 N ANGIER, NC 27501
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C 000	Initial Comments	C 000		
C 153	<p>10A NCAC 13G .0501 (a) Personal Care Training And Competency</p> <p>10A NCAC 13G .0501 Personal Care Training And Competency</p> <p>(a) The facility shall assure that personal care staff and those who directly supervise them in facilities without heavy care residents successfully complete a 25-hour training program, including competency evaluation, approved by the Department according to Rule .0502 of this Section. For the purposes of this Subchapter, heavy care residents are those for whom the facility is providing personal care tasks listed in Paragraph (i) of this Rule. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 2 of 2 sampled Staff (A and B) had documentation of successfully completing a 25-hour personal care training program, including competency evaluation.</p> <p>The findings are:</p> <p>1. Review of the personnel record for Staff A revealed: -Staff A was the Licensee and Administrator for the facility.</p>	C 153		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 153	<p>Continued From page 1</p> <ul style="list-style-type: none"> -Staff A was a Medication Aide (MA) in the facility. -There was no documentation of successfully completing 25 hours of personal care training. <p>Interview on 7/27/16 at 2:30pm with Staff A revealed:</p> <ul style="list-style-type: none"> -Residents were mostly independent, with the need of supervision for bathing and dressing occasionally for a resident. -There were no heavy care residents. -She thought she had certification in personal care when she was checked off by the facility nurse in medication clinical skills. -She thought MAs did not need training in personal care. -She would check with the nurse to obtain the training and competency documentation in personal care and supervision. <p>No documentation of personal care training was provided prior to the end of the survey.</p> <p>2. Review of the personnel record for Staff B revealed:</p> <ul style="list-style-type: none"> -Staff B was hired in April of 2016. -Staff A was hired as a Resident Technician. -There was no documentation of successfully completing 25 hours of personal care training in the personnel record. <p>Staff B was not available for interview.</p> <p>Interview on 7/27/16 at 2:15 p.m. with the Administrator/Licensee revealed:</p> <ul style="list-style-type: none"> -Residents were mostly independent with the need of supervision for bathing or supervising dressing occasionally for a resident. -There were no heavy care residents. -Staff B was hired as a Resident Technician and Medication Aide (MA). 	C 153		

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C 153	<p>Continued From page 2</p> <ul style="list-style-type: none"> -She thought MAs did not need training in personal care. -Staff B provided direct personal care to all residents. -She thought Staff B's training in personal care was checked off in the Medication Clinical Skills by the facility nurse. -She would check with the nurse to obtain the personal care skills training and documentation for Staff B. <p>No documentation of personal care training was provided by the end of the survey.</p> <p>Interview with a resident on 3/22/16 at 2:55 p.m. revealed:</p> <ul style="list-style-type: none"> -The resident was mostly independent but staff assisted with personal care as needed for all residents. -Staff helped by keeping rooms neat and cleaned, doing laundry, cooking meals, encouraging residents to exercise, and assisting with grooming and dressing. -Both staff provided personal care as needed and as requested by the residents. 	C 153		
C 171	<p>10A NCAC 13G .0504(a) Competency Validation For Licensed Health</p> <p>10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks</p> <p>(a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff</p>	C 171		

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C 171	<p>Continued From page 3</p> <p>performing the task and that their ongoing competency is assured through facility staff oversight and supervision.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure that 2 of 2 sampled staff (Staff A and B) were competency validated for Licensed Health Professional Support (LHPS) tasks of application and removal of prosthetic devices (Resident #2) and oxygen administration and monitoring (Resident #1).</p> <p>The findings are:</p> <p>1. Review of Staff A's personnel file revealed: -Staff A was hired on 1/1/16. -She was the Licensee and Administrator of the facility -There was no documentation of a completed LHPS competency validation.</p> <p>Interview on 7/27/16 at 2:15pm with Staff A revealed: -She had worked at the facility since 1/1/16. -She had not been competency validated for assisting with a prosthetic device or for oxygen administration and monitoring. -She was not aware of the requirement that an appropriate licensed health professional must participate in an on-site review and evaluation of the residents' health status, care plan, and care provided for residents requiring personal care assistance with a prosthetic device or for oxygen administration and monitoring. -She thought the clinical skills checklist was all that was required. -She was not aware of the LHPS competency validation checklist. -She thought all required training had been</p>	C 171		
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C 171	<p>Continued From page 4</p> <p>completed.</p> <p>-As the Administrator, she was responsible for making sure training had been completed.</p> <p>2. Review of Staff B's personnel file revealed:</p> <p>-Staff B was hired in April 2016 (no day noted in date of hire).</p> <p>-She was hired as the Resident Technician, responsible for personal care tasks.</p> <p>-There was no documentation of LHPS competency validation in her personnel file.</p> <p>-She had not been competency validated for assisting with a prosthetic device or for oxygen administration and monitoring.</p> <p>Staff B was not available for interview during the survey on 7/27/16.</p> <p>The facility Nurse Consultant was not available for interview.</p> <p>Interview with Resident #1 at 3:15pm on 7/27/16 revealed:</p> <p>-She preferred to manage her own oxygen administration.</p> <p>-She did not need anyone checking on her.</p> <p>-She had difficulty with her balance and her ankle support since her accident.</p> <p>-Her feet and ankles were still painful and swollen.</p> <p>-She was able to walk unaided by using her walker.</p> <p>-Staff were responsive to her requests for assistance and her equipment needs.</p> <p>Interview with Resident #2 at 3:00pm on 7/27/16 revealed:</p> <p>-Sometimes he wore his prosthesis and sometimes he used crutches to ambulate.</p> <p>-Staff offered to help with his prosthesis, but he</p>	C 171		

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C 171	Continued From page 5 could manage it on his own, too. -Staff checked the padding on the prosthesis. -Staff checked his stump for skin breakdown.	C 171		
C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure 3 of 3 residents sampled (#1, #2, and #3) had a two-step Tuberculosis (TB) skin test in compliance with the control measures adopted by the Commission for Health Services upon admission.</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 6/30/16 revealed diagnoses included schizoaffective disorder, hypertension, hypothyroidism, and chronic obstructive pulmonary disease.</p> <p>Review of the Resident Register for Resident #1 revealed she was admitted to the facility on 1/15/16.</p>	C 202		

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C 202	<p>Continued From page 6</p> <p>Review of a TB skin test for Resident #1 revealed: -A TB skin test was given on 9/7/15. -The test was read as negative (0 mm) on 9/10/15. -There was no documentation of a second TB skin test in the record.</p> <p>Interview with Resident #1 on 7/27/16 at 1:30pm revealed: -She had many TB skin tests in her lifetime, and all were negative. -She had one TB skin test this past year.</p> <p>Refer to interview with the Administrator on 7/27/16 at 3:45pm.</p> <p>2. Review of Resident #2's current FL-2 dated 1/5/16 revealed diagnoses included depression, psychosis, hypertension, insomnia, right leg amputee, dyslipidemia, and dysthymia.</p> <p>Review of Resident #2's Resident Register revealed he was admitted to the facility on 1/15/16.</p> <p>Review of a TB skin test for Resident #2 revealed: -A TB skin test was given, but no date of the testing was documented. -The test was read as negative (0 mm) on 2/10/16. -There was no documentation of a second TB skin test in the record.</p> <p>Interview with Resident #2 on 6/27/16 at 1:45pm revealed he had one TB skin test this past year.</p> <p>Refer to interview with the Administrator on</p>	C 202		

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C 202	Continued From page 7 7/27/16 at 3:45pm. 3. Review of Resident #3's current FL-2 dated 2/9/16 revealed diagnoses included schizoaffective disorder, metastatic laryngeal cancer, chronic obstructive pulmonary disease, coronary artery disease, hypertension, and acute cholecystitis. Review of the Resident Register for Resident #3 revealed he was admitted to the facility on 1/7/16. Review of TB skin test for Resident #3 revealed: -A TB skin test was given on 2/8/16. -The test was read as negative (0 mm) on 2/10/16. -There was no documentation of a second TB test in the record. Resident #3 was not available for interview. Refer to interview with the Administrator on 7/27/16 at 3:45pm. _____ Interview with the Administrator at 3:45pm on 7/27/16 revealed: -She did not realize all residents were required to have a two-step TB test. -She was responsible for assuring all residents received two step TB skin testing. -Residents #2 and #3 had been residing at the facility under the previous licensee, she took over as of 1/1/16.	C 202		
C 238	10A NCAC 13G .0802 (c) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan	C 238		

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C 238	<p>Continued From page 8</p> <p>(c) The care plan shall include the following: (1) a statement of the care or service to be provided based on the assessment or reassessment; and (2) frequency of the service provision.</p> <p>This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure a care plan was developed and signed by the assessor for 2 of 3 sampled residents (#2 and #3).</p> <p>The findings are:</p> <p>1. Review of Resident #2's current FL-2 dated 1/5/16 revealed: -Diagnoses included depression, psychosis, hypertension, insomnia, right leg amputee, dyslipidemia, and dysthymia. -The resident was ambulatory with the assistance of crutches. -The resident was continent of bowel and bladder.</p> <p>Review of Resident #2's care plan dated 1/5/16 revealed: -The Activities of Daily Living (ADL) section of the care plan was blank. -The "Other" section of the care plan was blank, which was to include Licensed Health Professional Support (LHPS) tasks and any other special care needs. -The resident was noted to have one LHPS task of assisting with a prosthetic device which was not listed on the care plan. -The assessor did not sign or date the care plan.</p>	C 238		

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C 238	<p>Continued From page 9</p> <p>Refer to interview with the Administrator on 7/27/16 at 2:45pm.</p> <p>2. Review of Resident #3's current FL-2 dated 2/9/16 revealed: -Diagnoses included schizoaffective disorder, metastatic laryngeal cancer, chronic obstructive pulmonary disease, coronary artery disease, hypertension, and acute cholecystitis. -The resident was noted to be semi-ambulatory. -The resident was continent of bowel and bladder.</p> <p>Review of Resident #3's care plan dated 1/5/16 revealed: -The care plan was not completed. -The Activities of Daily Living (ADL) section of the care plan was blank. -The assessor did not sign or date the care plan.</p> <p>Refer to interview with the Administrator on 7/27/16 at 2:45pm.</p> <p>Interview with the Administrator on 7/27/16 at 2:45pm revealed: -The Administrator completed the residents' assessments. -She was unaware she had to sign the assessor certification portion of the care plan. -She thought the ADL section of the care plan did not have to be completed if a resident was mostly independent.</p>	C 238		
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications,</p>	C 330		

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C 330	<p>Continued From page 10</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and medication orders were listed on the Medication Administration Record for 1 of 3 residents sampled (#3).</p> <p>The findings are: Review of Resident #3's current FL-2 dated 2/9/16 revealed diagnoses included schizoaffective disorder, metastatic laryngeal cancer, chronic obstructive pulmonary disease, coronary artery disease, hypertension, and acute cholecystitis.</p> <p>Review of a physician's medication order dated 6/5/16 revealed: -The medication order was for Oxycodone-acetaminophen (Percocet) 5-325 mg. -The frequency was one tablet by mouth every 6 hours as needed for pain for up to 10 days. -The start date was 6/5/16 and the end date was 6/15/16.</p> <p>Review of Resident #3's June 2016 Medication Administration Record (MAR) revealed: -There was an entry for Oxycodone-acetaminophen (Percocet) 5-325.mg one tablet every 6 hours as needed for pain for up to 10 days.. -The medication was administered to the resident on 6/6/16-6/8/16; 6/11/16; 6/14/16; 6/22/16; and</p>	C 330		

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C 330	<p>Continued From page 11</p> <p>6/24/16.</p> <p>Review of Resident #3's July 2016 MAR revealed there was no entry for Oxycodone-acetaminophen (Percocet) 5-325.mg.</p> <p>Review of Resident #3's controlled substance count log for the Percocet revealed: -Percocet was administered as ordered on 6/6/16-6/9/16; 6/11/16; and 6/14/16. -Percocet was administered after the stop date of 6/15/16 on 6/22/16; 6/24/16 and 7/21/16. -There were 29 pills remaining.</p> <p>Observation of medications on hand on 7/27/16 revealed there was a blister pack of Percocet for Resident #3 with 29 pills remaining.</p> <p>Interview with the Administrator on 7/27/16 at 3:30pm revealed: -She did not know why the Percocet was administered beyond the stop date of 6/15/16 as ordered by the physician. -She did not know why the medication was not listed on the July MAR or why it was administered on 7/21/16. -She would return the medication to the pharmacy.</p>	C 330		