STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001146	A. BUILDING: _____ B. WING _____	09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOUNTIFUL BLESSINGS FCH	208 GILMER STREET BURLINGTON, NC 27217

(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 09/05/19 and 09/09/19.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F for 6 of 6 fixtures including one tub, two showers, and three sinks used by residents. The findings are: Observations of the facility on 09/05/19 from 8:45am to 8:50am revealed: -There were two bathrooms accessible to residents. -There was a main bathroom located in the main hallway; there were two sinks, a commode, a shower and a tub. -The temperature of the water at both sink fixtures was 139 degrees F. -The temperature of the water at the shower fixture was 138 degrees F.	C 105		

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C 105	Continued From page 1 -The temperature of the water at the tub fixture was 139 degrees F. -There was a second bathroom accessible through a resident bedroom; there was a sink, a commode and a shower. -The water temperature of the water at the sink fixture was 138 degrees F. -The temperature of the water at the shower fixture was 138 degrees F. -There was a temperature log posted in the main bathroom on the wall. Review of the temperature log posted in the bathroom revealed: -There were parameters for hot water temperatures listed and circled on the top of the log; the parameters were 100 degrees F to 116 degrees F. -Temperatures were documented once a week beginning on 07/23/19 and ending on 09/03/19; there were seven dates and temperatures documented. -The lowest temperature documented was 105 degrees F and the highest temperature was documented as 106 degrees F. -The documentation for each reading was signed off by the Administrator. Observation of the Administrator on 09/05/19 at 9:21am revealed: -She used a digital thermometer to take the temperature of the water in the main bathroom at the sink fixtures at both sinks. -The Administrator's digital thermometer read the water temperature at both sink fixtures was141 degrees F; there was steam coming from the stream of water at the fixture. -She made a phone call and asked someone on the phone to come to the facility to adjust the temperature on the hot water tank.	C 105		

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C 105	Continued From page 2	C 105		

-She informed the residents of the hot water temperatures and hung a caution sign on the doors of the bathrooms with a warning to residents about the hot water temperatures.

Interview with a resident on 09/05/19 at 8:53am revealed:
-She turned on the water and adjusted the temperature herself for her showers or when she washed her hands.
-She liked the temperature of the water "between" hot and cold.
-She had never been burned and she had not heard of another resident getting burned by hot water.

Interview with a second resident on 09/05/19 at 9:01am revealed:
-She could bathe herself but one of the staff would set the water temperature in the shower for her; she would stick her hand into the running water to test the temperature before she got into the shower.
-After she sat down on the shower chair inside the shower, she could adjust the temperature if it was too hot or too cold by herself and sometimes, she had to cool it down.
-She never got burned by the water when she took a shower or when she washed her hands.

Interview with a third resident on 09/05/19 at 9:10am revealed:
-She took her showers by herself, she washed her hands by herself and she could adjust the water temperature the way she liked it.
-She had never gotten burned by hot water and she did not think the water was too hot.

Interview with the Supervisor-in-Charge (SIC) on 09/05/19 at 4:30pm revealed:

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C 105	Continued From page 3 -She did not monitor the temperature for the hot water; the Administrator took temperatures and maintained the temperature log in the bathroom. -The Administrator would call a local repairman if there was a problem with the hot water tank or hot water temperatures. -Residents had not complained about the temperature of the hot water; no one had gotten burned on the hot water. -She prepared the shower for one resident and she adjusted the temperature for the resident; she did not notice if the water was too hot when she prepared the water for the resident to take a shower. -The other residents could adjust the water temperatures themselves. Interview with the Administrator on 09/05/19 at 9:13am revealed: -She prepared the baths and showers for only one resident; the other residents could take a shower and adjust the water temperature themselves. -None of the residents had complained about the water temperature being too hot. -None of the residents had been burned by hot water. -She called a local repairman to relight the hot water tank two weeks ago because the pilot light blew out; she called him periodically to adjust the temperature. -She thought the water temperature could not be higher than 106 degrees for residents. -She had a digital thermometer and she kept a record of water temperatures from the sink in the main bathroom. -She had taken the temperature of the water in the main bathroom at the sink on 09/03/19 and it was 106 degrees F.	C 105		

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C 105	Continued From page 4 A second interview with the Administrator on 09/05/19 at 9:30am revealed: -None of the residents had complained to her about the water being too hot. -She had a water temperature log posted in the bathroom for July 2019, August 2019 and September 2019 but she did not keep old logs; the water temperature had been consistently 106 degrees F. -The temperature of the hot water had been as high as 120 degrees F but that was a long time ago and she did not remember the date. -She called a local repairman to turn down the temperature on the hot water tank when the temperature was too high. -She did not document when the repairman came to turn down the hot water temperature. Review of a handwritten note dated 09/05/19 from a local repairman revealed at 12:55pm he had adjusted the temperature of the hot water tank. Observation of the main bathroom and the second bathroom on 09/05/19 at 2:45pm revealed the temperatures of the hot water at the sink fixtures and showers in both bathrooms were 103 degrees F. The facility failed to assure hot water temperatures for 6 of 6 fixtures used by residents were maintained between 100 - 116 degrees F. The water temperatures ranged from 138 degrees F to 139 degrees F. A water temperature of 131 degrees F can result in a first degree burn in 17 seconds and a second degree burn in 30 seconds. The failure of the facility to ensure water temperatures were between 100 - 116 degrees F resulted in substantial risk for	C 105		

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C 105	Continued From page 5 injury to the three residents and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/05/19 for this violation. THE CORRECTION DATE SHALL NOT EXCEED OCTOBER 09, 2019 FOR THE TYPE A2 VIOLATION.	C 105		
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 record reviews and interviews, the facility failed to assure 1 of 2 sampled staff (A) had a criminal background check completed prior to hire. The findings are: Review of Staff A's personnel record revealed: -Staff A was the Supervisor-in-Charge and Medication Aide (SIC/MA) and there was no documentation of a hire date. -There was no documentation of a signed consent for a criminal background check for Staff A. -There was no documentation a criminal background check had been completed for Staff A.	C 147		

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C 147	Continued From page 6 Interview with the Staff A on 09/05/19 at 4:28pm revealed: -She worked as the SIC and as a MA. -She had worked at the facility since it opened; she thought her hire date was in October 2012. -She knew she had signed a consent for a criminal background check when she started. -She had seen the completed criminal background check report in her personnel record, but she did not know what happened to the document. -The Administrator kept the personnel records; she had nothing to do with the records. Interview with the Administrator on 09/09/19 at 8:44am revealed: -She was responsible for the completion of the criminal background check for Staff A. -She had completed the criminal background check for Staff A prior to hire, sometime in October 2012. -She checked personnel records every two months, but she had not noticed Staff A's criminal background check was missing from the record. -She would run another criminal background check for Staff A if she could not find a copy of the document.	C 147		
C 190	10A NCAC 13G .0601 (c-2) Mangement And Other Staff 10A NCAC 13G .0601 Management And Other Staff (c) When the administrator or supervisor-in-charge is absent from the home or not within 500 feet of the home, the following shall apply:	C 190		

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C 190	Continued From page 7 (2) For recurring or planned absences, a relief-supervisor-in-charge designated by the administrator shall be in charge of the home during the absence and in the home or within 500 feet of the home according to the requirements in Paragraph (b) of this Rule. The relief-supervisor-in-charge shall meet all of the qualifications required for the supervisor-in-charge as specified in Rule .0402 of this Subchapter with the exception of Item (4) pertaining to the continuing education requirement. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record review and interviews, the facility failed to assure there was a relief supervisor-in-charge in the facility or within 500 feet of the facility, when the administrator was absent from the facility. The findings are: Observation of the facility on 09/05/19 at 8:10am revealed a female person was present in the facility with three residents; the Administrator and the supervisor-in-charge (SIC) were not in the facility. Review of personnel records on 09/05/19 at 3:00pm revealed the female person did not have a personnel record. Interview with the female person on 09/05/19 at 8:10am revealed: -She was not the Administrator and she was not the SIC.	C 190		

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-She did not administer medication and she was not a medication aide (MA); she was not a personal care aide (PCA).
-She was alone with the residents and had been alone since 6:30am; the Administrator had been there that morning and had left.
-She was in the facility with the residents because the Administrator was running an errand.
-She was only at the facility while the Administrator ran errands and when the SIC was not there.
-She relieved the SIC and the Administrator only in the mornings.

Interview with a resident on 09/05/19 at 8:35am revealed:
-The only staff the facility had were the Administrator, the SIC and the female person.
-The SIC stayed overnight and the Administrator was at the facility during the day.
-The female person was only in the facility in the mornings while the Administrator was "gone"; the female person was usually at the facility for an hour or two.
-The female person did not do anything for her because she could do everything herself.

Interview with a second resident on 09/05/19 at 8:53am revealed:
-The female person worked in the facility alone two or three times a week.
-The female person worked in the mornings for one to two hours.

Interview with a third resident on 09/05/19 at 9:01am revealed:
-She liked the female person but did not know when female person was at the facility or how often.
-She did not think the female person did anything

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C 190	Continued From page 9 for her; the Administrator administered medication to her. Interview with the SIC/MA on 09/05/19 at 4:53pm revealed: -The female person relieved her in the mornings and stayed for one hour at a time, but not every day. -The female person stayed alone with the residents but did not pass medication. -The female person was at the facility a couple of times a week; the female person would be at the facility "here and there". -The female person usually came in the mornings when the Administrator could not be there. -The female person had been "filling in" at the facility for two years. Interviews with the Administrator on 09/05/19 at 8:21am and 8:39am revealed: -She went to the local grocery store and had only left the female person alone with the residents that morning for a few minutes before she returned to the facility because the female person called her. -The female person only filled in for an hour for the Administrator while she would run errands -The female person did not prepare meals or pass medication. -The female person would also go to the store for her. -She started her shift every day at the facility at 5:30am and worked until the SIC relieved her in the evening; the SIC's shift was 5:30pm to 5:30am. -The SIC stayed overnight with the residents and was also a MA and passed medication. A second interview with the Administrator on 09/05/19 at 3:07pm revealed:	C 190		

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C 190	Continued From page 10 -She did not have a personnel record for the female person. -The female person was a family member and did not get paid for her work. -The female person would be alone with the residents for close to an hour in the mornings. -The female person had a test for tuberculosis (TB) disease and a certification in cardiopulmonary resuscitation (CPR) but she did not have record of either document. -The female person had been helping her out for about two years. -The female person had come to the facility somewhere between 7:45am and 8:00am that day; she had only planned to leave the female person for an hour while she went to the local grocery store. A third interview with the Administrator on 09/09/19 at 8:38am revealed: -The female person was at the facility alone with the residents one hour at a time, four to five days a week while she ran small errands. -The last times the female person was alone with the residents at the facility was for twenty minutes on 09/03/19 and 09/05/19. _____ The facility failed to assure there was a qualified supervisor-in-charge or Administrator within 500 feet of the facility. The residents were left alone without supervision or qualified staff and put at risk by lack of someone to administer medication or CPR in the event of an emergency. This failer resulted in serious neglet of the residents and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/09/19 for this violation.	C 190		

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C 190	Continued From page 11 THE CORRECTION DATE SHALL NOT EXCEED OCTOBER 09, 2019 FOR THE TYPE A2 VIOLATION	C 190		
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 record reviews and interviews, the facility failed to assure 1 of 4 sampled residents (#4) was tested for tuberculosis (TB) disease upon admission. The findings are: Review of Resident #4's current FL2 dated 09/09/19 revealed diagnoses included hypertension, congestive heart failure, depression, obesity, gout, and atrial fibrillation. Review of Resident #4's Resident Register revealed there was no admission date. Review of Resident #4's record revealed: -There was documentation a TB test was	C 202		

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C 202	Continued From page 12 administered on 09/04/19; there was no documentation the TB test had been read after it had been administered. -There was no other documentation for TB testing. Interview with Resident #4 on 09/09/19 at 8:11am revealed: -She was admitted to the facility on Friday, 09/06/19 in the afternoon; she lived at home before she moved into the facility. -She had a TB skin test administered last week but she could not remember the day. -She did not know who but she thought someone was supposed to take her to get her TB test read today, 09/09/19. Interview with the Administrator on 09/09/19 at 8:44am revealed: -Resident #4 was admitted on 09/06/19; she had lived at home with a family member prior to her admission. -Resident #4's family member was supposed to take Resident #4 to get the TB test read before the resident was admitted. -She could not reach Resident #4's family member by phone and the family member was not returning phone calls. -She knew Resident #4 was required to have her TB test read prior to admission to the facility. -She would have to take Resident #4 to have the TB test read if the family member did not take her by the end of the day.	C 202		
C 259	10A NCAC 13G .0904(a)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care	C 259		

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C 259	Continued From page 13 Homes: (4) There shall be at least a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus, for both regular and therapeutic diets. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to assure there was a three-day supply of perishable food and a five-day supply of non-perishable food maintained in the facility based on the menus for the three residents residing at the facility. The findings are: Interview with the Administrator on 09/05/19 at 8:21am revealed there was a census of three residents and all three residents were on a regular diet. Observation on 09/05/19 at 8:30 am of the facility's food supply revealed the following items were not available in the facility for serving as compared to the regular diet menu for 3 days: -Breakfast on 09/05/19: Orange juice. -Lunch on 09/05/19: Lasagna, vegetable blend, Italian bread, and pear salad. -Dinner on 09/05/19: BBQ for BBQ sandwich, onion rings, Brunswick stew and fruit cobbler. -Breakfast on 09/06/19: Orange juice, pancakes, milk and dry cereal. -Lunch on 09/06/19: Baked fish, stewed potatoes, cornbread, coleslaw and chocolate pudding. -Dinner on 09/06/19: Lettuce, tomato and onion, hamburger buns, baked beans, milk and pineapple salad. -Breakfast on 09/07/19: Orange juice, white or	C 259		

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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 259	Continued From page 14 wheat toast, and milk. -Lunch on 09/07/19: Baked ham, sweet potato, fresh fruit and dinner roll. -Dinner on 09/07/19: Chicken alfredo with pasta, stewed tomatoes, cornbread and milk, Observation of the refrigerator on 09/05/19 at 8:28am revealed: -There was a fourth of a gallon container of 2 percent milk. -There was one pound of ground beef. -There were 4 fresh eggs. -There was one pound of ground sausage. -There was less than a fourth of a gallon of apple juice. -There was one pound of bacon. -There was a fourth of a pound bag of shredded cheddar cheese. -There was less than a fourth of a container of dried oatmeal. -There was less than a fourth of a container of grits. -There were two eight-ounce cartons of nutritional supplements that had expired in May 2019. Observation of the freezer on 09/05/19 at 8:28am revealed: -There was a 12-inch frozen pizza. -There were four pounds of ground turkey. -There was an opened bag of collard greens and an opened bag of broccoli; each bag was half full. -There were 15 waffles. -There was a package of eight hot dog buns. -There was a four-and-a-half-pound package of chicken legs. Observation of a chest style freezer on 09/05/19 at 8:30am revealed: -There was 20 pounds of ground beef. -There was six pounds of ground turkey.	C 259		

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C 259	Continued From page 15 -There were three 12-inch frozen pizzas. Observation of the non-perishable food supply in the pantry on 09/05/19 at 8:40am revealed: -There were three 10.5-ounce cans of condensed tomato soup. -There were four 4.6-ounce cans of Vienna sausage. -There was a 10 ounce can of tomato sauce. -There was a 12 ounce can of cranberry sauce. -There was a 14.5 ounce can of asparagus that expired in 2014. -There was a 14.5 ounce can of pink salmon that expired in January 2018. Observation of the facility on 09/05/19 at 8:50am revealed a gentleman that was not facility staff brought bags of food and supplies to the facility. Observation of the lunch meal on 09/05/19 at 11:41am revealed: -There were three residents present for the lunch meal. -Each resident was served a breaded beef patty between two slices of white bread, mixed vegetables, canned fruit cocktail and water. -Two residents ate 90 percent of their meals and one resident ate 100 percent. Observation of the dinner meal on 09/05/19 at 5:45pm revealed: -A 10-inch pizza was delivered to the facility by a local restaurant. -Each resident was served two slices of pizza, green beans, fruit cocktail and water. Interview with three residents on 09/05/19 at 8:35am and 5:00pm revealed: -They never saw the weekly or daily menu, so they did not know what they were supposed to be	C 259		

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served for meals.
-For breakfast that day they had country ham and oatmeal, but did not have eggs, grits, sausage, milk or toast.
-Most mornings they had coffee and oatmeal for breakfast and nothing else; they got eggs occasionally.
-The Administrator's husband prepared food at home and brought it to the facility; he cooked hot dogs, fish, chicken, macaroni and cheese, and vegetables for meals.

Interview with the Supervisor-in-Charge on 09/05/19 at 5:15pm revealed:
-She did not always cook dinner because the Administrator's husband cooked the meat and she would cook the vegetables.
-She would look in the refrigerator and decide what to cook or ask the Administrator what she wanted her to cook.
-She did not cook breakfast because her shift ended well before breakfast; the Administrator cooked breakfast.
-When she cooked she would call the Administrator to bring items she needed for the menu for the day or when she did not have what she needed to cook a meal.

Interview with the Administrator on 09/05/19 at 3:53pm revealed:
-She had planned to go to the grocery store to shop for food that day, Thursday, 09/05/19.
-She usually shopped every Monday for food and supplies.
-She "had not made it to the store this week" because she had "other things going on".
-She usually bought enough for the week and then "picked up" items as they ran out.
-She usually spent sixty dollars to one hundred and fifty dollars every time she bought groceries.

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C 259	Continued From page 17 -She knew she needed three days' worth of perishables and five days of nonperishables; she "did not think she had enough food for three days" in the facility. -The last time she bought groceries was Monday, 08/26/19 the week before; she spent fifty dollars. -She could not remember everything she bought last week but she remembered buying hamburger buns, sausage, ketchup and coffee; she did not keep the receipts from the grocery store. The facility failed to assure there was a three-day supply of perishable food and a five-day supply of non-perishable food maintained in the facility based on the menus for the three residents residing at the facility. The residents did not have an adequately balanced diet based on the food supplies available or enough food supplies on hand should there have been an emergency. This failure was detrimental to the residents' health and wlfare which constitues a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/09/19 for this violation. THE CORRECTION DATE SHALL NOT EXCEED OCTOBER 24, 2019 FOR THE TYPE B VIOLATION	C 259		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available	C 272		

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C 272	Continued From page 18 to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to offer snacks three times a day to the three residents residing in the facility. The findings are: Observation of the facility on 9/05/19 at various times from 8:10am to 6:10pm revealed: -Snacks were not listed on the weekly menue and there was not a menu for snacks or a snack schedule available. -Snacks were not offered to residents. -Snacks were not available in the food storage areas. Interviews with three residents on 09/05/19 at 8:53am and 5:37pm revealed: -Snacks were not offered to residents. -Sometimes they asked for snacks if there were snacks in the facility; they used to get crackers or cookies. -They would like snacks. -One of the resident's family sent her snacks. Interview with the Supervisor-in-Charge on 09/05/19 at 4:30pm revealed: -The residents did not eat snacks, so the Administrator stopped offering them. -One of the resident's family sent her snacks to eat and she would ask for them. Interview with the Administrator on 09/05/19 at 4:08pm revealed: -She used to offer snacks to the residents, but they always refused so she stopped offering	C 272		

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C 272	Continued From page 19 them. -The residents never asked for snacks. -She stopped purchasing snacks because the residents did not eat them, and the snacks went "to waste". -She knew she was supposed to offer snacks but there was no point in offering because the residents always refused.	C 272		
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, record reviews and interviews, the facility failed to assure fruit was served twice daily to the residents, including one serving of 100% fruit juice. The findings are: Observation of the food supply on 09/05/19 at 8:29am revealed: -There was no canned, fresh or frozen fruit in the facility. -There was an opened container of 100% apple	C 274		

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C 274	Continued From page 20 juice in the facility with less than a fourth of a gallon remaining. Review of the menu for 09/05/19 revealed: -Orange juice was listed on the menu for breakfast. -Pear salad was listed on the menu for lunch. -Fruit cobbler was listed on the menu for dinner. Interview with a resident on 09/05/19 at 8:53am revealed: -She was not served juice or fruit at breakfast that morning. -She liked juice and had juice on the days the Administrator went to the grocery store. -She had canned pineapple the day before at lunch; but she did not get fruit every day. -When she got fruit with her meal it, was at lunch. Interview with a second resident on 09/05/19 at 9:01am revealed: -She liked orange juice, but she had not had orange juice in over a month. -She thought she had pineapple for lunch the day before but could not remember if it was fresh or canned. Interview with a third resident on 09/05/19 at 9:10am revealed: -She only had juice when the Administrator bought it; she was not offered juice but would drink juice if it was offered. -She had not had fresh fruit in a long time; she could not remember when she last had fresh fruit. -She had canned fruit for lunch sometimes. Interview with the supervisor-in-charge (SIC) on 09/05/19 at 4:30pm revealed: -She did not work during the day; she did not serve breakfast or lunch only dinner.	C 274		

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C 274	Continued From page 21 -The residents had fresh pineapple the day before. -The Administrator would bring in groceries; she did not pay attention to what food the Administrator brought in unless she prepared a meal. Interview with the Administrator on 09/05/19 at 3:53pm revealed: -She went to the grocery store on Mondays. -The residents had fresh sliced pineapple the day before, bananas on Saturday, and fresh orange slices last week. -The residents did not like fruit juice and did not drink it; the residents drank a lot of water. -She bought canned fruit cocktail with cherries and peaches. -She needed to go to the grocery store.	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 reviews and interviews, the facility failed to assure a nutritional supplement was served as ordered for 1 of 3 sampled residents (#3) with physician orders for a nutritional supplement. The findings are: Review of Resident #3's current FL-2 dated	C 284		

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C 284	Continued From page 22 01/07/19 revealed diagnoses included Dandy Walker syndrome, coronary artery disease, hypertension, peripheral vascular disease, prediabetic, renal insufficiency, and aortic insufficiency. Review of Resident #3's record revealed a physician's order dated 07/25/19 for the nutritional supplement three times a day. Observation of the dry storage and the refrigerator on 09/05/19 at 8:28am revealed there were two eight-ounce cartons of a vanilla nutritional supplement that had expired in May 2019; there were no other cartons of nutritional supplements available. Observation of the dry storage and the refrigerator on 09/09/019 at 7:15am revealed there was no nutritional supplements available. Interview with Resident #3 on 09/05/19 at 4:55pm revealed: -She was not offered a nutritional supplement and she was not served one with her meals. -She would have drunk a nutritional supplement between meals; she would have liked a chocolate nutritional supplement. -She did not think she had been offered a supplement in a very long time; she could not say how long it had been since she had drunk a supplement. Interview with a representative from Resident #3's physician's office on 09/06/19 at 1:42pm revealed: -Resident #3 was ordered the nutritional supplement due to decreased appetite. -If the resident was not receiving the supplement the result would be insufficient daily calorie intake	C 284		

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which could result in weight loss over a prolonged period of time.
-The order had not been discontinued so Resident #3 should have continued to receive the supplement.
-The facility staff did not inform the physician Resident #3 was not getting the nutritional supplement.
-Weights had not been ordered by the physician.

Interview with the Supervisor-in-Charge (SIC) on 09/05/19 at 5:15pm revealed she did not know anything about Resident #3's nutritional supplements; the only thing she knew was the Administrator bought the nutritional supplements and they were stored on the chest freezer.

Interview with the Administrator on 09/05/19 at 4:08pm revealed:
-Resident #3 had been ordered the nutritional supplement because she gagged and coughed a little bit when she was eating.
-She had thrown out the supplement over the weekend because it had expired; Resident #3 would not drink the supplement and would refuse it when offered.
-She only served Resident #3 the supplement at meals and never offered it between meals.

A second interview with the Administrator on 09/09/19 at 8:50am revealed:
-She had not bought any nutritional supplements for Resident #3 because she had not had a chance.
-She was going to call Resident #3's physician and ask for the supplement to be discontinued because Resident #3 refused to drink it anyway and it "always got wasted".
-She could not remember the last time she gave Resident #3 the nutritional supplement.

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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, record reviews, and interviews, the facility failed to assure medications were administered as ordered for 2 of 3 sampled residents (Residents #1 and #2) including a medication for allergy relief (#1) and an antihistamine (#2). The findings are: 1. Review of Resident #1's current FL2 dated 07/02/19 revealed: -Diagnoses included rheumatoid arthritis, osteoporosis, gastroesophageal reflux disease, anemia, neuropathy, Vitamin D deficiency, chronic pain syndrome, and chronic obstructive pulmonary disease. -There was an order for fluticasone nasal spray (a medication used to relieve allergy symptoms) 50 mcg two sprays in each nostril once a day. Review of Resident #1's Medication Administration Record (MAR) for July 2019 revealed there was not an entry for fluticasone nasal spray.	C 330		

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C 330	Continued From page 25 Review of Resident #1's MAR for August 2019 revealed: -There was an entry for fluticasone nasal spray 50 mcg two sprays in each nostril once a day scheduled at 8:00am. -Fluticasone was documented as administered thirty-one out of thirty-one days as scheduled. Review of Resident #1's MAR for September 2019 revealed: -There was an entry for fluticasone nasal spray 50 mcg two sprays in each nostril once a day scheduled at 8:00am. -Fluticasone was documented as administered five out of five days as scheduled. Observation of Resident #1's medications on hand on 09/05/19 at 12:54 pm revealed: -There were two bottles of fluticasone 50mcg nasal spray . -There was a bottle with a dispense date of 01/29/19 and one fourth of fluticasone remained in the bottle. -There was a second unopened bottle with a dispense date of 06/24/19. Observation of Resident #1 on 09/05/19 at 8:35am revealed her hands and fingers had large joints and were severely twisted and malformed; she did not have use of all her fingers. Interview with Resident #1 on 09/05/19 at 8:35am revealed she had not eaten breakfast that morning because she was "exhausted from sneezing". A second interview with Resident #1 on 09/05/19 at 4:55pm revealed: -She took the fluticasone for allergies; she	C 330		

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"sneezed a lot without it", like she did that morning.
-The Administrator placed the bottle of nasal spray at her place setting every morning for her to use herself.
-The Administrator did not watch her use the nasal spray because the Administrator had other things to do and would walk away.
-She had arthritis in both of her hands.
-The top of the fluticasone bottle had to be pushed down for the bottle to spray the medication into her nose; it was hard for her to put the bottle in her nose and push the top of the bottle down at the same time spray because the arthritis in her hands was so bad.
-She knew when she had received a dose of the nasal spray because she could feel it go into her nose.
-She did not use the nasal spray every day because somedays her arthritis in her hands would be "too bad"; she did not tell the Administrator about the times she did not use the spray.
-She never complained to the Administrator about the difficulty she had using the nasal spray because she wanted to do it herself.

Telephone interview with a representative from the contracted pharmacy on 09/05/19 at 1:51pm revealed:
-There was an active order was for fluticasone nasal spray 50mcg two sprays in each nostril once a day.
-The last two dispense dates were 01/29/19 and 06/24/19; there were 120 sprays per bottle.
-The facility staff called the pharmacy for refills on medications; no medication was on an auto fill or cycle fill.
-If the bottle of nasal spray dispensed on 01/29/19 had been administered as ordered then

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Resident #1 would have had more dispense dates prior to 06/24/19.
-If Resident #1 had not received the fluticasone nasal spray as ordered she could have difficulty breathing through her nose or increased sneezing.

Attempted telephone interviews with Resident #1's physician on 09/05/19 at 3:47pm and on 09/06/19 at 1:54pm were unsuccessful.

Interviews with the Administrator on 09/05/19 at 12:32 pm and 3:53pm revealed:
-She administered medications to all residents.
-She would reorder medication when the medication only had three to four days left; the pharmacy delivered the same day.
-She placed Resident #1's nasal spray on the table in the morning and she watched Resident #1 spray the nasal spray into her own nose.
-She did not know why the fluticasone was not on the MAR for the month of July 2019; she was sure Resident #1 got the nasal spray every day.
-She did not know how many doses of nasal spray were in the bottle of fluticasone; she thought the nasal spray that was dispensed on 01/29/19 should have been "used up".
-Resident #1 had problems breathing and sneezing if she did not use the nasal spray.

2. Review of Resident #2's current FL2 dated 11/07/18 revealed:
-Diagnoses included cellulitis of limb, muscle weakness, difficulty walking, anemia, sacral pressure ulcer, peripheral venous insufficiency, hypertension and diabetes mellitus.
-There was an order for cetirizine (an antihistamine used to treat allergies) 10 mg once daily.

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C 330	Continued From page 28 Review of Resident #2's Medication Administration Record (MAR) for July 2019 revealed: -There was an entry for cetirizine 10 mg take at bedtime for allergy symptoms scheduled at 8:00pm. -Cetirizine was documented as administered thirty-one days out of thirty-one days as scheduled. Review of Resident #2's MAR for August 2019 revealed: -There was an entry for cetirizine 10 mg take at bedtime for allergy symptoms scheduled at 8:00pm. -Cetirizine was documented as administered thirty-one out of thirty-one days as scheduled. Review of Resident #2's MAR for September 2019 revealed: -There was an entry for cetirizine 10 mg take at bedtime for allergy symptoms scheduled at 8:00pm. -Cetirizine was documented as administered five out of five days as scheduled. Observation of Resident #2's medications on hand on 09/05/19 at 12:31 pm revealed: -There was only one medication card with cetirizine tablets for Resident #2. -The dispense date on the medication card was 10/15/19 and thirty tablets were dispensed. -There were three tablets remaining in the card. Telephone interview with a representative from the contacted pharmacy on 09/05/19 at 1:51pm revealed: -There was an active order for cetirizine for Resident #2. -Thirty tablets had been dispensed on 10/15/18;	C 330		

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the facility staff had ordered another refill on 09/05/19.
-This medication was not on an auto fill or a cycle fill.
-If Resident #2 had not taken the cetirizine as ordered she might have sneezing and difficulty breathing though her nose, also symptoms could get worse over time.

Interview with Resident #2 on 09/05/19 at 4:55pm revealed:
-She only took two pills a day and she took both pills in the morning; she did not take any medication at night.
-She thought she took a medication for allergies; she had not had allergy problems for a long time.

Telephone interview with Resident #2's physician on 09/06/19 at 5:01pm revealed:
-He had ordered the cetirizine for Resident #2 for her allergies.
-He expected to be contacted by the facility staff when a resident refused or missed any medication.

Interview with the Supervisor-in-Charge (SIC) on 09/05/19 at 4:35pm revealed:
-She administered Resident #2 the cetirizine every night.
-She did notice the dispense date on the package was from October 2018; she could not explain why she was administering from a package from October.

Interview with the Administrator on 09/05/19 at 12:32pm revealed:
-She gave Resident #2 the cetirizine but the SIC administered Resident #2 the cetirizine most evenings.
-She did not know why Resident #2's cetirizine

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C 330	Continued From page 30 had an "old" dispense date of 10/15/18 on it; she knew Resident #2 received her medication every evening. -She ordered Resident #2 her cetirizine every month. _____ The facility failed to ensure medications were administered for 2 of 3 sampled residents (#1 and #2) as ordered by the physician which resulted in Resident #1 who did not receive their nasal spray and suffered from allergy symptoms and not being able to function and participate in a meal. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility has not provided a plan of protection in accordance with G. S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 09, 2019.	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	C 342		

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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, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records for 3 of 3 sampled residents (Residents#1, #2 and #3) related to the documentation of the administration of a medication for allergy relief (#1), an antihistamine (#2), and blood presure medication (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 07/02/19 revealed:
-Diagnoses included rheumatoid arthritis, osteoporosis, gastroesophageal reflux disease, anemia, neuropathy, Vitamin D deficiency, chronic pain syndrome, and chronic obstructive pulmonary disease.
-There was an order for fluticasone nasal spray (a medication used to relieve allergy symptoms) 50 mcg two sprays in each nostril once a day.

Review of Resident #1's Medication Administration Record (MAR) for July 2019 revealed there was not an entry for fluticasone spray.

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C 342	Continued From page 32 Review of Resident #1's MAR for August 2019 revealed: -There was an entry for fluticasone nasal spray 50 mcg two sprays in each nostril once a day scheduled at 8:00am. -Fluticasone was documented as administered thirty-one out of thirty-one days as scheduled. Review of Resident #1's MAR for September 2019 revealed: -There was an entry for fluticasone nasal spray 50 mcg two sprays in each nostril once a day scheduled at 8:00am. -Fluticasone was documented as administered five out of five days as scheduled. Observation of Resident #1's medications on hand on 09/05/19 at 12:54 pm revealed: -There were two bottles of fluticasone nasal spray. -There was a bottle dispensed on 01/29/19 and there was one fourth of fluticasone remaining in the bottle. -There was a second unopened bottle dispensed on 06/24/19. Interview with Resident #1 on 09/05/19 at 4:55pm revealed: -The Administrator placed the bottle of nasal spray at her place setting every morning for her to use herself. -The Administrator did not watch her use the nasal spray because the Administrator had other things to do and walked away. -She did not use the nasal spray every day because she had difficulty pushing the top; she did not tell the Administrator about the times she did not use the spray.	C 342		

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C 342	Continued From page 33 Telephone interview with a representative from the contracted pharmacy on 09/05/19 at 1:51pm revealed: -The active order was for fluticasone nasal spray 50mcg two sprays in each nostril once a day. -The last two dispense dates were 01/29/19 and 06/24/19. -There were 120 sprays per bottle; one bottle should have lasted 30 days. -He did not know why the order for the fluticasone was not on the MAR for July 2019; "sometimes orders fall off". -If the facility had let the pharmacy know the fluticasone order was not on the MAR the pharmacy would have printed a new MAR. Interview with the Administrator on 09/05/19 at 3:53pm revealed: -She administered medications to all residents and documented on the MAR. -She placed Resident #1's nasal spray on the table in the morning and Resident #1 sprayed the nasal spray into her own nose. -She watched Resident #1 use the spray; Resident #1 sprayed two times into each nostril. -She documented administration of the medication after Resident #1 used the nasal spray. -She checked the MARs against the medication when medication came in at the beginning of the month, but she did not notice Resident #1's fluticasone was not on the MAR for July. -She did not know why the fluticasone was not on the MAR for the month of July 2019; she was sure Resident #1 got the nasal spray every day. -She did not know how many doses of nasal spray were in the bottle of fluticasone; she thought the nasal spray that was dispensed on 01/29/19 should have been "used up".	C 342		

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C 342	Continued From page 34 2. Review of Resident #2's current FL2 dated 11/07/18 revealed: -Diagnoses included cellulitis of limb, muscle weakness, difficulty walking, anemia, sacral pressure ulcer, peripheral venous insufficiency, hypertension and diabetes mellitus. -There was an order for cetirizine (an antihistamine used to treat allergies) 10 mg once daily. Review of Resident #2's Medication Administration Record (MAR) for July 2019 revealed: -There was an entry for cetirizine 10 mg take at bedtime for allergy symptoms scheduled at 8:00pm. -Cetirizine was documented as administered thirty-one days out of thirty-one days as scheduled. Review of Resident #2's MAR for August 2019 revealed: -There was an entry for cetirizine 10 mg take at bedtime for allergy symptoms scheduled at 8:00pm. -Cetirizine was documented as administered thirty-one out of thirty-one days as scheduled. Review of Resident #2's MAR for September 2019 revealed: -There was an entry for cetirizine 10 mg take at bedtime for allergy symptoms scheduled at 8:00pm. -Cetirizine was documented as administered five out of five days as scheduled. Observation of Resident #2's medications on hand on 09/05/19 at 12:31 pm revealed: -There was only one medication card with cetirizine tablets for Resident #2.	C 342		

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C 342	Continued From page 35 -The dispense date on the medication card was 10/15/19 and thirty tablets where dispensed. -There were three tablets remaining in the card. Telephone interview with a representative from the contacted pharmacy on 09/05/19 at 1:51pm revealed thirty tablets had been dispensed on 10/15/18; the facility had ordered another refill on 09/05/19. Interview with Resident #2 on 09/05/19 at 4:55pm revealed she only took two pills a day and she took both pills in the morning; she did not take any medication at night. Interview with the Supervisor-in-Charge (SIC) on 09/05/19 at 4:35pm revealed: -She documented on the MAR every time she administered any medication to residents. -She administered Resident #2 the cetirizine every night and documented on Resident #2's MAR. -If the order was on the MAR, the resident got the medication. Interview with the Administrator on 09/05/19 at 12:32pm revealed: -She documented on the MAR when she gave Resident #2 the cetirizine. -The SIC administered Resident #2 the cetirizine most evenings. -She did not do MAR audits. 3. Review of Resident #3's current FL-2 dated 01/07/19 revealed: -Diagnoses included Dandy Walker syndrome, coronary artery disease, hypertension, peripheral vascular disease, prediabetic, renal insufficiency, and aortic insufficiency. -There was an order for hydralazine HCL (used to	C 342		

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treat high blood pressure) 50mg take three times a day.

Review of Resident #3's physicians orders dated 01/16/19 revealed an order for hydralazine 50 mg take four times a day.

Review of Resident #3's Medication Administration Record (MAR) for July 2019 revealed:
-There was an entry for hydralazine HCL 50 mg take four times a day scheduled at 8:00am, 12:00pm, 4:00pm and 12:00am.
-Hydralazine was documented as administered thirty-one days out of thirty-one days as scheduled.

Review of Resident #3's MAR for August 2019 revealed there was not an entry for hydralazine.

Review of Resident #3's MAR for September 2019 revealed there was not an entry for hydralazine.

Observation of Resident #3's medication on hand on 09/05/19 at 12:17 revealed:
-There were two a medication cards for hydralazine HCL 50 mg for Resident #3.
-The dispense date on the medication cards were 08/26/19 and there were 120 tablets dispensed, 60 tablets per card.
-There were 21 hydralazine tablets remaining in the first card and 60 tablets remaining in the second card.

Interview with Resident #3 on 0905/19 at 9:01am revealed:
-The Administrator administered her medication most of the time and the Supervisor-in-Charge (SIC) gave it to her sometimes.

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C 342	Continued From page 37 -She did not know when she was administered her medications or what medications she took. Telephone interview with a representative from the contacted pharmacy on 09/05/19 at 1:51pm revealed: -There was an active order for hydralazine 50 mg for Resident #3. -The last two dispense dates for the hydralazine were 7/25/19 and 8/26/19; 120 tablets for a 30 day supply were dispensed each time. -He did not know the hydralazine order was not listed on the MARs for August 2019 and September 2019; sometimes orders will "drop off" of a MAR when they become a year old. -The facility staff should have notified the pharmacy the hydralazine order was not on the MAR and they would have sent out a new MAR. Interview with the Supervisor-in-Charge (SIC) on 09/05/19 at 4:30pm revealed: -She documented on the MAR every time she administered any medication to residents. -She would look at the MAR and then find the card with the medication and then "pop" the tablet into a cup to give to the resident; after the resident took the medication, she would document on the MAR. -If a medication was not on the MAR, she did not administer it. -She did not notice Resident #3's hydralazine order was not on the MAR. -She thought she had administered the hydralazine to Resident #3 in August 2019 and September 2019 even though it was not on the MAR; she knew Resident #3 needed the hydralazine. -When an order was not on the MAR the Administrator would handwrite it in.	C 342		

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C 342	Continued From page 38 Interview with the Administrator on 09/05/19 at 4:08pm revealed: -She documented on the MAR when she administered medication to residents. -She compared the MARs to the medications when she administered medication to residents and when new MARs were delivered from the pharmacy. -She had not noticed Resident #3's hydralazine order was not on the MAR for September until today during the 12:00pm medication pass; she wrote the hydralazine order on the MAR when she made the discovery. -She never noticed the hydralazine was not on Resident #3's MAR for August 2109. -She knew Resident #3 had been administered the hydralazine four times a day even though it was not on the MAR; she had administered the hydralazine to Resident #3 herself in August 2019 and September 2019.	C 342		
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 observations, record reviews, and interviews, the facility failed to assure the residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to building service equipment, management and other staff, nutrition and food	C 912		

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C 912	Continued From page 39 services and tuberculosis testing. The findings are: 1. Based on observation, interview and record review, the facility failed to assure hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 6 of 6 fixtures (sinks, bath-tub, and showers) used by residents. [Refer to Tag C105, 10A NCAC 13G .0317(d) Building Service Equipment (Type A2 Violation)]. 2. Based on observation, record review and interviews, the facility failed to assure there was a supervisor-in-charge in the facility or within 500 feet of the facility. [Refer to Tag C190, 10A NCAC 13G .0601(c)(2) Management and Other Staff (Type A2 Violation)]. 3. Based on observations, record reviews, and interviews, the facility failed to assure medications were administered as ordered for 2 of 3 sampled residents (Residents #1 and #2) including a medication for allergy relief (#1) and an antihistamine (#2). [Refer to Tag C330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]. 4. Based on observations, interviews, and record reviews the facility failed to assure there was a three-day supply of perishable food and a five-day supply of non-perishable food maintained in the facility based on the menus for the three residents residing at the facility. [Refer to Tag C259, 10A NCAC 13G .0904(a)(4) Nutrition and Food Service(Type B Violation)].	C 912		