STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011025	A. BUILDING: _____ B. WING _____	R 03/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW FAMILY CARE HOME # 4	256 GRAVELY BRANCH ROAD FLETCHER, NC 28732

(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 a follow-up survey with an onsite visit on 03/17/21 and a desk review survey on 03/18/21 with a telephone exit on 03/18/21.	{C 000}		
{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: FOLLOW UP TO A TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 2 of 3 sampled residents (#1 and #2) related to a missed podiatry appointment for improper fitting diabetic shoes and a missed neurology consult for seizures (Resident #1) and dental work and colonoscopy for preventative health maintenance (Resident #2). The findings are: 1. Review of Resident #1's current FL-2 dated 10/29/20 revealed diagnoses included restless legs syndrome (RLS), diabetes, chronic obstructive pulmonary disease (COPD), and paranoid schizophrenia. a. Review of Resident #1's caregiver notes revealed: -Resident #1 had a podiatry appointment scheduled on 03/04/21 at 2:30pm.	{C 246}		

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{C 246}	Continued From page 1 -The Supervisor-in-Charge (SIC) completed the caregiver note. Interview with Resident #1 on 03/17/21 at 1:35pm revealed: -She did not know she had an appointment with her foot doctor in March 2021. -She had an appointment scheduled on 04/08/21. -Her feet were hurting in her new boots. -It felt like the boot was pinching her foot. Interview with the SIC on 03/17/21 at 1:23pm revealed: -Resident #1's primary care provider (PCP) wanted Resident #1 to get an appointment with the podiatrist because the resident was complaining that her feet were hurting. -Resident #1 had refused to go to the podiatry appointment on 03/04/21 because she was no longer having any "trouble with her feet." -She had called and cancelled the appointment. -She did not know Resident #1 had a podiatrist appointment scheduled in April 2021. -She was responsible for calling and canceling appointments if a resident refused to go. Telephone interview with Resident #1's PCP on 03/18/21 at 12:37pm revealed: -She had asked the SIC to schedule an appointment for Resident #1 to be evaluated by her podiatrist at her last visit with the resident in February 2021. -Resident #1 was complaining with her feet hurting. -Resident #1 had recently received new shoes and she was worried they were hurting the resident's feet. -If Resident #1's feet were not closely monitored then it put her at an increased risk of developing a diabetic foot ulcer.	{C 246}		

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{C 246}	Continued From page 2 Telephone interview with a nurse from Resident #1's podiatrist Office on 03/17/21 at 2:00pm revealed: -Resident #1 was a "no call, no show" for an appointment on 03/04/21. -Resident #1 had a history of missing appointments. -She missed an appointment on 10/05/20 that was rescheduled for 11/11/20 and an appointment on 01/22/21 that was rescheduled on 01/28/21. -Resident #1 was diabetic and was being seen in the office every 2 to 3 months for diabetic foot care. -Resident #1 had picked up new diabetic shoes on 01/25/21. -It was important for Resident #1 to make it to all your appointments for preventative care for diabetic foot ulcers. -Resident #1's new diabetic shoes could be hurting her feet and could lead to a diabetic foot ulcer if she was not monitored closely. -Diabetic foot ulcers were serious and could lead to an infection or an amputation. Refer to the interview with the Supervisor-in-Charge (SIC) on 03/17/21 at 1:23pm. Refer to the interview with the Property Manager on 03/17/21 at 1:10pm. Refer to the interview with the Administrator on 03/17/21at 1:15pm. b. Review of Resident #1's report of consultation notes from the primary care provider (PCP dated 03/20/20 revealed a referral to a neurologist.	{C 246}		

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{C 246}	Continued From page 3 Review of Resident #1's caregiver notes dated 02/11/21 revealed: -The Supervisor-in-Charge (SIC) had written the caregiver note. -Resident #1 had a neurology appointment scheduled for 02/11/21 and the resident had refused to go. Interview with Resident #1 on 03/17/21 at 11:29am revealed: -She did not know she had a neurology appointment in February 2021. -She did not remember refusing to go to an appointment. -She remembered having a siezure in the past. -She remembered being treated at the hospital for a seizure "a while back." Interview with the SIC on 03/17/21 at 11:08am revealed: -Resident #1's previous neurologist was no longer available for appointments. -She had to get Resident #1 a referral to a different neurology office. -Resident #1 had a telehealth appointment on 02/11/21 with the new neurologist but the resident had refused to attend the appointment. -Resident #1 did not like having to do a telehealth appointment and wanted to have an "in-person" appointment so she had to get a referral to the new neurologist for this type of appointment. -She had called Resident #1's primary care provider's (PCP) office and was told the referral had been faxed to the neurologist. -She had called the new neurology office and they had not received the referral paperwork. -She did not remember what days she had made the call to the PCP office or the neurology office. -She was waiting on Resident #1's PCP office to refax the referral paperwork to the new neurology	{C 246}		

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{C 246}	Continued From page 4 office. Telephone interview with a nurse from Resident #1's new neurology office on 03/18/21 at 9:27am revealed: -Resident #1's information was not in the computer system and there had never been an appointment scheduled for the resident at the office. -She did not have Resident #1's information in the "referral folder" where the office kept all recent referral request. Telephone interview with the referral specialist at Resident #1's PCP office on 03/17/21 at 3:05pm revealed: -She had not sent the referral information to the neurology office because she was waiting to get authorization from the facility. -She had reached out to the facility and never got in touch with anyone. -No one from the facility had returned her call to give authorization for her to fax the referral. -The referral was ordered because Resident #1 needed treatment for a seizure disorder. Telephone interview with Resident #1's PCP on 03/18/21 at 12:37pm revealed: -Resident #1 had a thirty-year history of seizures but she had no documentation of an evaluation. -She had made two referrals to the facility for Resident #1 to have an appointment with a neurologist. -Resident #1 needed a neurology evaluation so her seizures could be monitored and treated. -It was important for Resident #1 to have an evaluation to prevent any future seizures. Refer to the interview with the Supervisor-in-Charge (SIC) on 03/17/21 at	{C 246}		

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{C 246}	Continued From page 5 1:23pm. Refer to the interview with the Property Manager on 03/17/21 at 1:10pm. Refer to the interview with the Administrator on 03/17/21at 1:15pm. 2. Review of Resident #2's current FL-2 dated 03/12/20 revealed diagnoses included schizoaffective personality disorder, hyperlipidemia, essential tremors, Vitamin D deficiency, asthma, and gastroesophageal reflux disease. Review of a physician's order sheet for Resident #2 dated 03/12/20 revealed there was an order for dental work and colonoscopy. a. Review of the physician's progress notes for Resident #2 revealed there were no progress notes for a dental visit. Interview with the Supervisor-in-Charge (SIC) on 03/17/21 at 10:30am revealed: -She did not know when Resident #2 had last been to the dentist. -She did not know if Resident #2 had gone to the dentist for dental work ordered 03/12/20. -She was responsible for reviewing physician's orders for referrals and follow-up appointments and scheduling Resident #2's appointments. -Transportation staff were responsible for taking Resident #2 to the appointments. Telephone interview with Resident #2's dentist on 03/17/21 at 12:15pm revealed: -Resident #2's last dental visit was 04/01/19 and included a deep cleaning on the left side of the mouth.	{C 246}		

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{C 246}	Continued From page 6 -Resident #2 had some tooth decay that required fillings and needed her four wisdom teeth extracted. -The facility had not called to schedule any appointments for Resident #2 since her last visit 04/01/19. -It was important for Resident #2 to have her teeth cleaned and fillings done because she could have increased teeth decay which could cause infection, pain, and loss of her teeth. -The dental office recommended biannual cleanings for Resident #2 for preventative maintenance of teeth decay, gingivitis, and general health of the teeth. Interview with Resident #2 on 03/17/21 at 1:09pm revealed: -She had not been to the dentist in "a long time". -She would go to the dentist if the facility would take her to her appointments. -The last visit to the dentist office was for a cleaning on the left side of her mouth. -She did not brush her teeth because the toothpaste turned her teeth yellow first and then green. -She only swished mouthwash around in her mouth for her dental hygiene. -Her teeth were sensitive to cold foods and drinks and would cause pain in her teeth. -Some of her teeth on both sides of her mouth hurt. -She relied on the SIC to schedule her dental appointments and "I never refuse to go to any of my appointments". Interview with the SIC on 03/17/21 at 1:25pm revealed: -The facility's process for referrals or scheduled appointments with resident's physicians was the Primary Care Physician (PCP) would send the	{C 246}		

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{C 246}	Continued From page 7 referral to another physician or dentist, the dental or physician's office the referral was sent to would call her to schedule the appointment, she would review the order and document it in a notebook, and the transportation staff would take the resident to their appointment. -If the dental office or physician's office did not call her within a couple of days to schedule an appointment for a referral, she would call them to follow-up. -She could not remember when Resident #2 had been taken to the dentist last. -She could not remember who had taken Resident #2 for the dental appointment, but they did not bring any paperwork back to the facility to file in Resident #2's record. -She did not know Resident #2 was supposed to return to the dentist for another cleaning on the right side of her mouth and to have fillings done for some teeth with decay. -She did not call the dental office to check if Resident #2 was supposed to follow-up for any dental care. -She had not called to schedule Resident #2 for a dental appointment and did not have a system in place for regular dental visits for preventative health. Telephone with Resident #2's Healthcare Power of Attorney (HCPOA) on 03/18/21 at 10:31am revealed: -Resident #2 had missed a few appointments with healthcare providers and the SIC told her it was because of COVID-19 and that Resident #2 could only attend virtual healthcare visits. -She did not know a dental referral was ordered on 03/12/20 for Resident #2. -She wanted Resident #2 to attend all the referral, scheduled, and follow-up appointments with healthcare providers.	{C 246}		

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{C 246}	Continued From page 8 -The SIC called her about any concerns for Resident #2 but she "doesn't call very often". Refer to the interview with the Supervisor-in-Charge (SIC) on 03/17/21 at 1:23pm. Refer to the interview with the Property Manager on 03/17/21 at 1:10pm. Refer to the interview with the Administrator on 03/17/21at 1:15pm. b. Review of the physician's progress notes for Resident #2 revealed there were no progress notes for a colonoscopy. Interview with the SIC on 03/17/21 at 10:30am revealed: -She knew a colonoscopy had been ordered for Resident #2 on 03/12/20. -She had not called to schedule Resident #2 for the colonoscopy last year because she did not see the referral in Resident #2's medical record and did not realize a referral was written until the survey team told her about it when they visited the facility in February 2021. -She had called the gastroenterology office on 03/01/21 to schedule a colonoscopy for Resident #2 but they would not schedule the appointment until the Healthcare Power of Attorney (HCPOA) and Health Insurance Portability and Accountability Act (HIPAA) forms were filled out for Resident #2. -She sent the HCPOA and HIPAA forms to Resident #2's HCPOA to fill out the first week of March 2021. -She was responsible for reviewing physician's orders for referrals and follow-up appointments and scheduling Resident #2's appointments.	{C 246}		

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{C 246}	Continued From page 9 Telephone interview with a representative from the gastroenterology office on 03/17/21 at 12:30pm revealed: -There was a comment entered into the computer system that a call was made to the facility on 06/12/20 to schedule a colonoscopy for Resident #2 and the person they spoke to (no name was documented in the computer system) said they would call back on Monday 06/15/20 to schedule the appointment for Resident #2 and "never did". -The referral was only good for one year. -The facility staff had not contacted the office to schedule a colonoscopy for Resident #2 prior to 03/01/21. -The facility staff called to schedule an appointment for a colonoscopy for Resident #2 on 03/01/21 but was told they would have to fill out some documents, send them back to the office, and then call again to schedule the appointment. -The office faxed the HCPOA and HIPAA forms to the facility for Resident #2 on 03/01/21. -The office received the HCPOA and HIPAA documents back from the facility for Resident #2 on 03/12/21. -The facility staff had not tried to call the office to schedule an appointment for Resident #2's colonoscopy since they had received the documents back from the facility. -The colonoscopy was a "preventative health screening but it is still important" for Resident #2. Interview with Resident #2 on 03/17/21 at 1:09pm revealed: -She did not know she was supposed to have a colonoscopy. -She would go to have a colonoscopy procedure if the facility would take her to the appointment. -She relied on the SIC to schedule her physician's appointments.	{C 246}		

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{C 246}	Continued From page 10 -She never refused to attend her healthcare appointments. Interview with the SIC on 03/17/21 at 1:25pm revealed: -The facility's process for referrals or scheduled appointments with resident's physicians was the Primary Care Physician (PCP) would send the referral to another physician, the physician's office the referral was sent to would call her to schedule the appointment, she would review the order and document it in a notebook, and the transportation staff would take the resident to their appointment. -If a physician's office did not call her within a couple of days to schedule an appointment for a referral, she would call them to follow-up. -She did not know who the gastroenterology office talked to when they called to schedule an appointment for Resident #2 on 06/12/20. -She did not know Resident #2 had a referral written in the physician's orders on 03/12/20 for a colonoscopy. -She had called a couple of weeks ago to schedule the colonoscopy for Resident #2 and "got the run around". -Herself and the SIC for a sister facility would get together once a month to call and schedule appointments for all the residents that needed them, so that they did not miss any appointments. Telephone with Resident #2's HCPOA on 03/18/21 at 10:31am revealed: -Resident #2 had missed a few appointments with healthcare providers and the SIC told her it was because of COVID-19 and that Resident #2 could only attend virtual healthcare visits. -The SIC had called her on 03/17/21 and asked her to write on letterhead paper "I am the legal guardian and want to request a colonoscopy" for	{C 246}		

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{C 246}	Continued From page 11 Resident #2 and fax it to the facility. -She did not know a colonoscopy was ordered on 03/12/20 for Resident #2. -She wanted Resident #2 to attend all the referral, scheduled, and follow-up appointments with healthcare providers. -The SIC would call her about any concerns for Resident #2 but she "doesn't call very often". Refer to the interview with the Supervisor-in-Charge (SIC) on 03/17/21 at 1:23pm. Refer to the interview with the Property Manager on 03/17/21 at 1:10pm. Refer to the interview with the Administrator on 03/17/21at 1:15pm. _____ Interview with the Supervisor in Charge (SIC) on 03/17/21 at 1:23pm revealed: -She was responsible for setting up appointments for the residents. -If a resident had a referral, she was responsible for making sure the referral information was sent to the new provider. -Usually once the new provider received the referral then they would call the facility to set up the appointment for the resident. Interview with the Property Manager on 03/17/21 at 1:10pm revealed: -He provided transportation for the residents to their appointments. -He had a calendar that he kept all the appointments recorded so he knew when he had to transport a resident to an appointment. -The SIC was responsible for letting him know when a resident had an appointment. -The SIC was responsible for scheduling	{C 246}		

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{C 246}	Continued From page 12 appointments for provider visits or procedures for the residents if needed unless a resident had a Guardian. Interview with the Administrator on 03/17/21at 1:15pm revealed: -It was the SIC's responsibility to schedule appointments for the residents and to notify the Property Manager so he could make sure he transported them to the appointment. -She did not know there were residents in the facility that had missed any appointments. The facility failed to ensure a resident with diabetes and diabetic shoes causing pinching and painful feet kept scheduled appointments with her podiatrist which placed the resident at risk for developing a diabetic foot ulcer and missed appointments with her neurologist for seizures (#1); and missed appointments for dental work including fillings for tooth decay and teeth cleaning and a colonoscopy for preventative health maintenance (#2). The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type Unabated B Violation.	{C 246}		
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.	C 330		

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C 330	Continued From page 13 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #3) related to a medication used to treat asthma. The findings are: Review of Resident #3's current FL-2 dated 11/05/20 revealed: -Diagnoses included schizophrenia, hyperplasia of prostate, and asthma. -There was a physician's order for Singular 10mg take 1 tablet daily (used to treat asthma). Review of Resident #3's March 2021 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Singular 10mg take 1 tablet daily scheduled to be administered at 8:00pm daily. -Singular was not documented as administered and was documented as "waiting on medication, pharmacy notified" for 13 out of 16 opportunities from 03/01/21 to 03/16/21. -Singular was documented as administered at 8:00pm on 03/08/21, 03/09/21, and 03/11/21. Observation of Resident #3's medication on hand on 03/17/21 at 10:30am revealed there were no Singular 10mg tablets available to be administered to the resident. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/17/21 at 12:03pm revealed:	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011025	A. BUILDING: _____ B. WING _____	R 03/18/2021

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C 330	Continued From page 14 -The pharmacy last dispensed Resident #3's Singular on 01/15/21 for a quantity of 30 tablets with the directions to take 1 tablet daily. -The pharmacy was waiting for a refill request to be returned from Resident #3's provider before they could dispense and the deliver the Singular to the facility for the resident. -The pharmacy was sending a list of medications that needed refills to the Property Manager of the facility weekly. -The facility had to know that Resident #3 was out of refills on the Singular. Interview with Resident #3 on 03/17/21 at 12:55pm revealed: -He had been feeling "short-winded" over the past 3 to 4 weeks and felt like he "couldn't breathe good." -He felt like it was "hard to get the air circulating in his system." Interview with the Supervisor-in-Charge (SIC) on 03/17/21 at 11:46pm revealed: -She knew Resident #3 did not have Singular available to be administered. -She had called the provider and then pharmacy multiple times requesting a refill. -The pharmacy told her the provider had refused to authorize refills. -She did not remember when she had called the pharmacy to get this information. Telephone interview with Resident #3's primary care provider (PCP) on 03/18/21 at 10:06am revealed: -It was important for Resident #3 to take his medication as prescribed. -He did not remember denying a refill request for Resident #3's Singular. -Resident #3 needed the medication to help treat	C 330		

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C 330	Continued From page 15 his asthma. -Resident #3 was at an increased risk for having difficulty breathing if he did not take his Singular daily. Interview with the Administrator on 03/17/21 at 1:10pm revealed: -The SIC was responsible for faxing or calling the provider if a resident needed refills on a medication. -She did not know Resident #3 was out of Singular and the medication was last refilled in January 2021.	C 330		
{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, interviews, and record reviews, the facility failed to ensure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to healthcare. The findings are: Based on interviews, and record reviews, the facility failed to ensure referral and follow-up for 2 of 3 sampled residents (#1 and #2) related to a missed podiatry appointment for improper fitting diabetic shoes and a missed neurology consult for seizures (Resident #1) and dental work and	{C 912}		

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{C 912}	Continued From page 16 colonoscopy for preventative health maintenance (Resident #2). [Refer to Tag 246, 10A NCAC 13F .0902(b) Health Care Referral and Follow Up (Type Unabated B Violation)].	{C 912}		