STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011022	A. BUILDING: _____ B. WING _____	R-C 05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW FAMILY CARE HOME # 1	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 an annual and follow-up survey onsite survey 04/27/21 to 04/29/21 with desk review on 04/30/21, and exit conference via telephone on 05/03/21.	C 000		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure adequate water supply in the men's common bathroom. The findings are: Observation of the men's common bathroom on 04/27/21 at 8:50am revealed: -Only a trickle of water was coming out of the faucet at the sink. -The bathtub had slightly more water coming out of the faucet. Interview with one resident on 04/27/21 at 9:02am revealed: -There was often only a "little bit" of water coming out of the sink. -The water pressure at the sink was "ok	C 102		

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C 102	Continued From page 1 sometimes" and "sometimes it wasn't." Observation in the facility hallway on 04/27/21 at 9:15am revealed the washing machine was in use. Interview with a second resident on 04/27/21 at 9:25am revealed: -The water pressure went "low sometimes" when the washing machine was running. -The water in the bathroom sinks would run slow and then become a "trickle." -"Sometimes" the water pressure dropped, because the water filters on the water line needed to be changed. Observation of the men's common bathroom on 04/27/21 at 2:09pm revealed: -Only a trickle of water was coming out of the faucet at the sink. -The bathtub had slightly more water coming out of the faucet. Interview with the Transport Staff on 04/27/21 at 10:00am revealed: -The facility had a 1000 feet deep well that provided water for the facility and a another family care home on the property. -There was a water filter on the water line. -There was also a water filter on the hot water heater. -Water pressure would decrease when the filters needed to be changed. -The water filters had been changed about "three weeks ago." -None of the residents had ever complained about decreased water pressure in the bathrooms. -The water pressure in the men's common bathroom could also be decreased when the	C 102		

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C 102	Continued From page 2 washing machine was running. Interview with the Administrator on 04/28/21 at 1:55pm revealed: -She normally did laundry for about 2 hours everyday. -Washing clothes caused the water pressure in the men's common bathroom to drop.	C 102		
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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled residents (Residents #1 and #3) had completed tuberculosis (TB) testing upon admission. The findings are: 1. Review of Resident #1's current FL2 dated 04/23/21 revealed diagnosis included	C 202		

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C 202	Continued From page 3	C 202		

hypertension, stage 3 chronic kidney disease, delusional disorder, ulcer of the left foot, and hypothyroidism.

Review of Resident #1's Resident Register revealed:
-Resident #1 was admitted on 10/07/19.
-Resident #1 was admitted from a local hospital.

Review of Resident #1's immunization records revealed there was no record of a first or second step TB skin test.

Interview with the Administrator on 04/29/21 at 1:55pm revealed:
-Resident #1 was admitted to the facility from a local hospital.
-She did not know Resident #1 did not have a TB skin test completed upon admission.
-She was responsible for arranging for the Licensed Health Professional (LHPS) Nurse to come out to the facility to perform TB skin tests for residents.

2. Review of Resident #3's current FL2 dated 02/10/21 revealed diagnoses included shortness of breath, benign prostatic hypertrophy, hypotension, depression, and hypothyroidism.

Review of Resident #3's Resident Register revealed:
-Resident #3 was admitted on 10/17/19.
-Resident #3 was admitted from a private residence.

Review of Resident #3's immunization records revealed:
-There was a negative TB skin test dated 10/08/19.
-There was no documentation of a second TB

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C 202	Continued From page 4 skin test. Interview with the Administrator on 04/29/21 at 1:55pm revealed: -She did not know why Resident #3 did not have a second TB skin test. -She thought Resident #3 was admitted from another assisted living facility. -She was responsible for arranging for the Licensed Health Professional (LHPS) Nurse to come out to the facility to perform TB skin tests for residents. The failure of the facility to complete TB testing upon admission for Resident #1 and a second step TB skin test for Resident #3 put all residents in the home at risk for exposure to TB thus was detrimental to the health, safety, and welfare of all residents and staff in the facility and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2021.	C 202		
C 230	10A NCAC 13G .0801(a) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. This Rule is not met as evidenced by:	C 230		

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C 230	Continued From page 5 Based on record review and interview, the facility failed to ensure an initial assessment was completed within 72 hours of admission using the Resident Register for 1 of 4 sampled residents (Resident #4). The findings are: Review of Resident #4's current FL-2 dated 01/21/21 revealed diagnoses included paranoid schizophrenia, mild mental retardation, asthma, obesity and tobacco abuse. Review of Resident #4's Resident Register on 04/28/21 revealed: -The admission date for Resident #4 was 03/03/21. -There were 4 pages to the Resident Register. -Page one was partially completed. -Pages two and three were blank. -Page four was missing the signature of the Supervisor or the Administrator. -Page four was signed and dated 03/03/21 by Resident #4's Guardian. Interview with the Administrator on 04/28/21 at 2:48pm revealed: -The Guardian was responsible for getting the Resident Register completed. -She did not know why the Guardian had not gotten this done yet. -She was not sure what to do for Resident #4 except to give medications, provide three meals each day and clean the room once a week. Interview with the Supervisor-In-Charge (SIC) on 04/29/21 at 10:10am revealed: -Resident #4's Guardian signed and dated the Resident Register the day she brought Resident #4 to the facility.	C 230		

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C 230	Continued From page 6 -Resident #4's Guardian was supposed to help fill out the Resident Register, but she never did.	C 230		
C 236	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure a care plan was developed for 1 of 4 sampled residents (Resident #4) within 30 days following admission. The findings are: Review of Resident #4's current FL2 dated 01/21/21 revealed: -Diagnoses included paranoid schizophrenia, mild mental retardation, asthma, chronic obstructive pulmonary disease, obesity and tobacco abuse. -Resident #4 was ambulatory, incontinent of bladder and had a functional limitation of speech. -No information was listed under personal care assistance. Review of Resident #4's Resident Register revealed an admission date of 03/03/21. Review of Resident #4's record revealed there was no care plan completed. Interview with the Administrator on 04/28/21 at	C 236		

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C 236	Continued From page 7 2:48pm revealed: -She was not aware there was not a care plan for Resident #4. -She did not know why there was not a care plan completed. -She was not sure what to do for Resident #4 except to give medications, provide three meals each day and clean the room once a week. -There should have been a care plan completed for Resident #4.	C 236		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 1 sampled residents (Resident #4) who needed smoking supervision. The findings are: Review of the Admission Policy and Procedures signed by Resident #4's Guardian on 03/03/21 revealed: -"The residents may only smoke outdoors." -If a resident fails to abide by the rules of this smoking policy, the facility has the right to confiscate all smoking and tobacco products. -"For the first offense, these products will remain with the facility staff for a period of three months	C 243		

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with supervision."
-For the second offense, confiscation will take place for a six- month period with supervision."
-The third violation of this policy will result in a resident having all smoking and tobacco products confiscated for the duration of the residents stay and a 30-day notice will be issued (resident will remain to be supervised until resident vacates facility)."
-An immediate discharge may be issued if continued smoking within the facility occurs; this is in direct violation of state law and is a danger to others residing in the home.

Review of Resident #4's current FL2 dated 01/21/21 revealed diagnoses included paranoid schizophrenia, mild mental retardation, chronic obstructive pulmonary disease (lung disease that causes obstructed airflow from the lungs), asthma and tobacco abuse.

Review of the Resident Register for Resident #4 revealed an admission date of 03/03/21.

Record review revealed no assessment for smoking safety for Resident #4.

Interview with Resident #4 on 04/27/21 at 8:53am revealed she smoked outside unsupervised..

Interview with the Supervisor-In-Charge (SIC) on 04/28/21 at 4:01pm revealed:
-Resident #4 had been caught smoking in her room on more than one occasion.
-Staff had kept Resident #4's smoking material since her admission to the facility.
-Resident #4 would ask through her bedroom window for cigarettes from other residents walking outside.

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C 243	Continued From page 9 Interview with the Transport Staff on 04/29/21 at 9:05am revealed: - Resident #4 had been given a 30-day notice on 04/22/21 due to not following "state rules." -She was smoking in her room and that was not safe. Review of the discharge notice dated 04/22/21 for Resident #4 revealed: -A 30-day notice was issued on 04/22/21. -The reason given was "she is not following state rules - she is smoking in her room - using the bathroom in her room - she refuses to follow rules." -The 30-day notice was addressed to "To whom it may concern." Telephone interview with Resident #4's Guardian dated 04/29/21 at 9:33am revealed: -She had moved Resident #4 from another family care home because she would not stop smoking in her room. -She brought Resident #4 to the facility on 03/03/21. -She was contacted by facility staff on 04/20/21 and told that Resident #4 was smoking in her room. -She made a visit to the facility on 04/22/21 and discussed with Resident #4 the possibility of losing her room there if she did not stop smoking in her room. -The Administrator gave her a 30-day discharge notice for Resident #4 before she left the facility on 04/22/21. Interview with the Administrator on 04/29/21 at 10:24am revealed: -She kept Resident #4's cigarettes and Resident #4 did not have a lighter. -She gave Resident #4 six cigarettes per day, two	C 243		

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C 243	Continued From page 10 after every meal. -She did not know who gave Resident #4 a lighter when she smoked because she did not have one for her. -The first time Resident #4 was smoking in her room was "about a week" after she came to the facility. -She was told that she could not smoke in her room and she had to smoke outside. -Resident #4 said she would nott smoke in her room anymore. -A few days later Resident #4 was smoking in her room again and was told she could nott smoke in her room and she had to smoke outside. -Resident #4 said she would not smoke in her room anymore. -Last week in the middle of the night, the smoke detector went off. -She went down the hall and could smell cigarette smoke coming out of Resident #4's room. -She knocked on the door and Resident #4 opened it with a lit cigarette in her hand. -She told Resident #4 again that she could not smoke in her room. -Resident #4 said she "would not do it anymore." -When Resident #4 went outside to smoke she was unsupervised. -Facility staff was too busy to sit outside with Resident #4 while she smoked. -She never told Resdient #4 she was at risk for losing her room at the facility if she did not stop smoking in her room. Interview with Resident #4 on 04/29/21 at 10:42am revealed: -She had 4 cigarettes in her room but no lighter. -She had never smoked in her room. The facility failed to provide supervision for 1 of 1 sampled residents (Resident #4) who had	C 243		

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C 243	Continued From page 11 multiple instances of smoking in her room. The facility's failure to supervise Resident #4 while smoking was detrimental to the health, safety and welfare of Resident #4 and constitutes a Type B violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/29/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 17, 2021.	C 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health care needs of 2 of 4 residents related to a psychiatric referral (#4), wound care orders (#1), and a protein supplement refusal (#1). The findings are: 1. Review of Resident #4's current FL2 dated 01/21/21 revealed diagnoses included paranoid schizophrenia, mild mental retardation, hypothyroidism, obesity, and tobacco abuse. Review of Resident #4's Resident Register revealed an admission date of 03/03/21.	C 246		

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C 246	Continued From page 12 Observation of Resident #4's room during intital tour on 04/17/21 at 8:53am revealed a very foul odor throughout the bedroom. Interview with Resident #4 during initial tour on 04/27/21 at 8:53am revealed: -She stayed in her room "mostly." -The staff clean her room "every few days." -Her room was most recently cleaned 2 days ago. Interview with the Administrator on 04/28/21 at 10:18am revealed: -Resident #4 never came out of her room except to smoke. -Resident #4 refused to come out to eat meals, use the bathroom or take a shower. -Resident #4 was using the bathroom in her briefs and putting them in her closet on towels in a cardboard box. -There was a strong odor in the closet and in the room. -She had asked Resident #4's Guardian to move her somewhere more appropriate. -Resident #4 received a bed linen change, a set of towels and wash cloths once a week. -Resident #4's room was cleaned once a week and her cardboard box was dumped into the dumpster with her soiled briefs, towels and wash cloths. -She had talked with Resident #4 about coming out of her room, taking a shower, and not using the bathroom in the closet. -Resident #4 would just stare at the wall and not say anything when she tried to talk with her about it. -Resident #4 did all her grooming and hygiene herself. -She gave Resident #1 medication three times a day, prepared a meal three times a day, and	C 246		

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cleaned her room once a week.
-"That's all I do for her."
-Resident #1 did not have a mental health provider that she knew of.
-She did not try to access any type of mental health services for Resident #4.

Observation of Resident #4's bedroom on 04/28/21 at 11:14am revealed:
-Resident #4 was lying down in bed and gave permission to open her closet door.
-There was a cardboard box on the floor in the closet.
-There were several briefs visibly soiled with feces and urine in the box.
-There were also towels that were visibly soiled with feces and urine in the cardboard box.
-Resident #4 would not talk about the cardboard box with soiled briefs and towels in the closet.

Interview with Resident #4 on 04/28/21 at 11:14am revealed she declined discussing the cardboard box in her closet.

A second interview with the Administrator on 04/28/21 at 1:52pm revealed:
-Resident #4's Guardian contacted her and asked if she had a bed available for a female resident "a few months ago."
-The only information she was given on Resident #4 was she liked to sleep during the day and stay up at night.
-She was not aware of any of Resident #4's diagnoses before she moved in.
-Resident #4 would not come out of her room or take a shower, and she used her closet as a bathroom.
-"I just don't know what I could have done differently."

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FAIRVIEW FAMILY CARE HOME # 1	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 246	Continued From page 14 Interview with a Supervisor-In-Charge (SIC) on 04/28/21 at 4:01pm revealed: -Resident #4 cannot be referred out for mental health services unless the Guardian is involved. -There should have been some type of intervention for Resident #4 before now. Telephone interview with Resident #4's Guardian on 04/29/21 at 9:33am revealed: -Staff at the facility notified her by phone on 04/20/21 that Resident #4 would not come out of her room and was using the closet for toileting. -She made a visit to the facility on 04/22/21 and was made aware by staff that Resident #4 had not bathed since she came to the facility. -She had received several texts from the staff at the facility since Resident #4's admission, but they were not relating to her hygiene issues or not leaving her room. -Resident #4 did not have a mental health provider because she did not have the problems she was having now regarding only eating in her room, not showering, and using the bathroom in her room. -She thought the facility should have informed her sooner that Resident #4 was only taking meals in her room, had not taken a shower or a bath since admission, and was using the closet for her bathroom. A second interview with Resident #4 on 04/29/21 at 10:42am revealed: -She ate all her meals in her room. -She had not taken a shower since coming to the facility. -She used body oils to clean herself with. -She wore briefs all the time and used the towels and wash cloths she received each week to clean herself. -She only went outside her room to smoke.	C 246		

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C 246	Continued From page 15 -There was a "tad" of a bad smell in the room, but it did not bother her. -She did all her personal care herself. -She declined to discuss the cardboard box of soiled briefs, towels and wash cloths in her closet. 2. Review of Resident #1's current FL2 dated 04/23/21 revealed: -Diagnosis included hypertension, stage 3 chronic kidney disease, delusional disorder, ulcer of the left foot, and hypothyroidism. -The resident was semi-ambulatory and incontinent of bladder and bowel "sometimes." Review of Resident #1's current Care Plan dated 10/28/20 revealed: -The resident required limited staff assistance with bathing. -The resident required limited assistance with ambulation/locomotion and required the use of a wheelchair. -The resident was documented as sometimes disoriented and forgetful; needed reminders. -The resident was documented as occasionally incontinent of bladder and bowel. a. Review of Resident #1's rehabilitation facility history and physical dated 02/02/21 revealed the resident was admitted for physical therapy after hospitalization for left heel infection. Review of Resident #1's rehabilitation facility discharge summary dated 02/13/21 revealed: -The primary admission diagnosis was acute osteomyelitis of the left ankle and foot. Review of a physician's order dated 02/13/21 revealed Pro-Stat Sugar Free (complete liquid	C 246		

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protein clinically supported to promote wound healing) 30ml by mouth daily for wound healing.

Observation of Resident #1's Pro-Stat Sugar Free on 04/27/21 at 4:20pm revealed:
-A 30 fluid ounce bottle of Pro-Stat Sugar Free.
-The bottle was open, undated, and almost completely full.

Telephone interview with a Pharmacist from the contracted facility pharmacy on 04/29/21 at 9:36am revealed:
-The Pro-Stat Sugar Free supplement was dispensed once on 02/15/21.
-The Pro-Stat dispensed on 02/15/21 should have provided a 29-day supply.

Review of Resident #1's February 2021 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Pro-Stat Sugar Free take 30ml every day for wound healing starting 02/16/21 to 02/26/21 scheduled at 8:00am.
-The Pro-Stat Sugar Free was documented as not administered on 02/16/21 due to "resident refused."
-The Pro-Stat Sugar Free was documented as administered daily at 8:00am from 02/17/21 to 02/26/21.

Review of Resident #1's March 2021 paper Medication Administration Record (MAR) revealed:
-There was an entry for Pro-Stat Sugar Free take 30ml every day for wound healing scheduled at 8:00am.
-The Pro-Stat Sugar Free was documented as administered daily at 8:00am from 03/01/21 to 03/31/21.

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C 246	Continued From page 17 Review of Resident #1's April 2021 MAR revealed: -There was an entry for Pro-Stat Sugar Free take 30ml every day for wound healing scheduled at 8:00am. -The Pro-Stat Sugar Free was documented as administered daily at 8:00am from 04/01/21 to 04/27/21. Interview with the Administrator on 04/27/21 at 4:21pm revealed: -Resident #1 refused to take the Pro-Stat Sugar Free as it was ordered. -She documented on the February, March, and April MARs the resident had taken it, however the resident had refused it each time she offered it to him. -She had not notified Resident #1's primary care provider the resident had refused the Pro-Stat. Telephone interview with Resident #1's Home Health Nurse on 04/27/21 at 4:48pm revealed: -She had been making visits to see Resident #1 to provide care for a left heel ulcer. -She had not been made aware Resident #1 had been refusing the Pro-Stat supplement. -The Pro-Stat was "important" for wound healing. -Resident #1's was scheduled to have surgery for a graft to the left heel ulcer to aid in wound healing. Telephone interview with Resident #1's Physician's Assistant (PA) on 04/28/21 at 10:23am revealed: -He was Resident #1's primary care provider. -He last saw Resident #1 on 04/23/21 for a pre-operative visit. -Resident #1 was scheduled to have surgery for a graft to a left heel ulcer. -He was not aware Resident #1 refused to take	C 246		

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the Pro-Stat supplement.
-He did not order the Pro-Stat supplement.

Telephone interview with a nurse from Resident #1's local rehabilitation facility on 04/30/21 at 9:22am revealed:
-The Pro-Stat Sugar Free had been ordered to be continued for Resident #1 at discharge.
-Resident #1 had received the Pro-Stat Sugar Free supplement while in the rehabilitation facility.
-"If he had refused it here, we would not have ordered it" to be continued at discharge.

b. Telephone interview with Resident #1's Home Health Nurse on 04/27/21 at 4:48pm revealed:
-Resident #1 had wounds on both of his shins and there were no orders on how to treat them.
-She had contacted Resident #1's Physician Assistant (PA) for wound care orders and the PA had refused to give her treatment orders.
-She had been keeping the wounds "clean and wrapped" to keep the resident from "hitting them."
-The shin wounds had healed "ok" "so far."

Observation of Resident #1's on 04/28/21 at 10:45am revealed:
-There was a 1 inch by 1 inch reddened circular indentation located on the resident's right mid-shin.
-There was a second area of scabbing 1 inch high by 1 inch wide approximately 1 inch below the circular indentation located on the resident's right shin.
-There were two small circular areas of scabbing on the resident's inner right upper ankle.
-The skin on the resident's right shin was red in color and appeared to be swollen.
-There was a 2 inch long area of scabbing located on the resident's left mid-shin.
-There was a second 1 inch long area of

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scabbing located 2 inches below the first area of scabbing.
-The skin on the resident's left shin was red in color and appeared to be swollen.
-There were no dressings on the resident's shin wounds.

Interview with the Home Health Nurse on 04/28/21 at 10:46am revealed:
-She had no dressing orders to treat the wounds on Resident #1's shins.
-The skin on the Resident's shins around the wounds was "red and warm to the touch."

Review of Resident #1's Home Health Nurse visit note dated 04/23/21 revealed:
-Resident #1 had an "abrasion to right shin."
-Resident #1 stated he had a "couple" falls in the past 2 days, but was unable to explain how the falls occurred.
-The resident stated he got the abrasion on the right shin from one of the falls.

Telephone interview with Resident #1's PA on 04/28/21 at 10:23am revealed:
-He was Resident #1's PCP.
-Resident #1's Home Health Nurse had reached out to him for dressing orders for bilateral shin wounds and he had refused to give dressing orders.
-He thought the Home Health Nurse could write orders for wound care.
-He last saw Resident #1 on 04/23/21 for a pre-operative visit.
-He saw the bilateral shin wounds during the resident's visit on 04/23/21.
-He had dressed the right shin wound on the 04/23/21 visit.
-Facility staff did not ask for dressing orders or for a referral to a wound care center for evaluation of

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C 246	Continued From page 20 the shin wounds and to obtain orders for wound care. Interview with the Transport Staff on 04/28/21 at 10:57am revealed: -He did not know Resident #1 had scabbed wounds on his left shin. -He became aware of Resident #1's right shin wounds on 04/18/21 or 04/19/21. -He had taken Resident #1 to see his PA on 04/23/21 and during the visit the PA had dressed the right shin wound and "put salve on it." -He did not ask for orders from the PA for continued wound care to the shin wounds. Interview with the Administrator on 04/28/21 at 1:55pm revealed: -The wounds on Resident #1's shins had been there "about 4 months." -The shin wounds had been there since the resident returned from the rehabilitation facility. -She had not notified Resident #1's PA about the shin wounds and she had not asked for orders on how to care for the shin wounds. -She was not responsible for notifying the PA about wounds or asking for orders to care for the wounds. -She thought the Home Health Nurse was responsible for notifying the PA about the wounds and obtaining orders to treat the wounds. -If a bandage came off a dressed wound, "we have to put it back on." The failure of the facility to follow up to obtain a psychiatric referral for Resident #4 resulted in the neglect of Resident #4 related to living in a room with feces and urine soiled incontinent briefs and soiled towels left in a cardboard box in a closet for a week at a time before being disposed of, not being bathed for 2 months, and not having had	C 246		

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C 246	Continued From page 21 oral care for 2 months which resulted in serious neglect of a resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/28/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 2, 2021.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and resident records, the facility failed to implement physician's orders for 1 of 4 sampled residents (Resident #4) with an order to be weighed weekly. The findings are: Review of Resident #4's current FL2 dated 01/21/21 revealed: -Diagnoses included hypertension, obesity, mild mental retardation and paranoid schizophrenia. -There was an order to "weigh once weekly on Wednesday."	C 249		

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C 249	Continued From page 22 Review of Resident #4's medical record and Medication Administration Record (MAR) since admission revealed there was no entry for weekly weights. Interview with the Administrator on 4/28/21 at 2:56pm revealed: -She did not know Resident #4's FL2 indicated she was to be weighed weekly. -There was no record of any weights for Resident #4 since no one had been taking them. Interview with Resident #4 on 4/28/21 at 3:02pm revealed: -She had not been weighed since coming to this facility. -She did not know if she had gained or lost weight since coming to this facility. Interview with Resident #4's Nurse Practitioner (NP) on 4/29/21 at 1:25pm revealed: -He had not seen Resident #4 since completing her FL2 on 01/21/21. -Resident #4 was prescribed a diuretic (excess fluid removing) along with an antihypertensive (lowers blood pressure) medication daily. -Part of determining the medication effectiveness for Resident #4's weight monitoring. -The facility was negligent if they are not following the FL2.	C 249		
C 280	10A NCAC 13G .0904(d)(3)(H) 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:	C 280		

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C 280	Continued From page 23 (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served in addition to other beverages to all residents at mealtimes. The findings are: Observation in the dining room for the lunch meal on 04/27/21 from 11:38am to 12:02pm revealed: -At 11:38am, there were 3 residents who had been served their lunch meal and beverages in the dining room. -Each resident was only served tea to drink. -No resident was observed to receive or be offered water throughout the lunch meal from 11:38am to 12:02pm. Interviews with the 3 residents who ate lunch on 04/27/21 between 11:54am and 12:04pm revealed: -Water was not served at every meal. -Water was available if you asked for it. -Sometimes water was available at lunch time and sometimes it was not. -They usually had water with their medications and at dinner. -Staff did not offer water for the lunch meal on 04/27/21. Interview with the Administrator on 04/27/21 at 12:06pm revealed: -She did not offer water at the lunch meal to the residents on 04/27/21. -If the residents wanted water, they could ask for it at any time. -She gave medication with water and served	C 280		

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C 280	Continued From page 24 water at dinner. -She was not aware the residents were supposed to be offered water at each meal. Observation in the dining room for the lunch meal on 04/29/21 beginning at 11:25am revealed: -At 11:25am, there were 3 residents who had been served their lunch and beverages in the dining room. -Each resident had a carbonated beverage to drink. -There was no offer of water from staff. Interviews with 2 of the 3 residents who ate lunch on 04/29/21 at 11:27am revealed neither of them had been offered water for the lunch meal. Interview with the Administrator on 04/29/21 at 11:29am revealed: -She had fixed the residents beverages for the lunch meal. -She had forgotten to offer water to the residents at the lunch meal.	C 280		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure resident rights were maintained for 3 of 5 residents sampled (Resident #1, #4, and #5) for not emptying a bed	C 311		

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side commode and providing briefs and toileting assistance and not providing assistance from a vehicle into the facility (#1), addressing a resident's fear of facility animals (#4), and residents paying staff to take them to the store and having access to do laundry (#3).

The findings are:

1. Review of Resident #1's current FL2 dated 04/23/21 revealed:
-Diagnosis included hypertension, stage 3 chronic kidney disease, delusional disorder, ulcer of the left foot, and hypothyroidism.
-The resident was semi-ambulatory with a wheelchair and incontinent of bladder and bowel "sometimes."

Review of Resident #1's current Care Plan dated 10/28/20 revealed:
-The resident required limited staff assistance with bathing.
-The resident was documented to have limited ability with ambulation/locomotion and required the use of a wheelchair.
-The resident was documented as sometimes disoriented and forgetful-needs reminders.
-The resident was documented as occasionally incontinent of bladder and bowel.

a. Interview with Transport Staff on 04/29/21 at 10:33am revealed:
-He had returned from taking Resident #1 to an appointment with a podiatrist.
-They had gone all the way to the podiatrist office only to realize the appointment was scheduled for the next day, 04/30/21.

Observation of Resident #1 on 04/29/21 at 10:35am revealed:

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C 311	Continued From page 26 -Resident #1 was seated in the front passenger seat of a minivan which had been parked at the bottom of the wheelchair ramp leading up to the facility entrance. -Transport Staff was seated in the front driver's seat of the minivan. -Transport Staff exited the minivan and entered the facility after loudly instructing a resident who resided at another family care home on the property to assist Resident #1 from the minivan into the facility. -A resident, who resided in another family care home on the property, went to the back of the minivan and removed a wheelchair. -The same resident then positioned the wheelchair outside the passenger door, opened the minivan passenger door, and assisted Resident #1 into the wheelchair. -The same resident had difficulty getting the wheelchair with Resident #1 seated in it to roll on the loose gravel in the parking area to the base of the ramp. -The same resident struggled to get the wheelchair with Resident #1 up the ramp. -After multiple unsuccessful attempts of the resident to roll the wheelchair up the ramp, Resident #1 removed the heel relief shoe from his bandaged left foot and put his weight on both of his feet and raised his body from the seat of the wheelchair to assist the other resident with getting the wheelchair up the steep incline of the ramp. -Resident #1 was agitated and embarrassed by the struggle to get inside the facility as there were several other residents outside who observed the interaction. Interview with Resident #1 on 04/29/21 at 10:50am revealed: -There were 3 residents who routinely assisted	C 311		

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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
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him out of the van, into his wheelchair, and up the ramp into the facility.
-He "usually" just got out of the wheelchair and dragged it up the ramp where he wanted it.
-"Everybody" had "trouble getting me and my chair" up the ramp.
-If the wheelchair had "pneumatic wheels," it would be "easier" to roll it on the gravel.

Review of Resident #1's Podiatrist visit note dated 04/09/21 revealed:
-Resident #1 was being seen by the Podiatrist for care of a left heel ulcer.
-Resident #1 was instructed on the importance to maintain strict non-weight bearing to the left lower extremity to allow for healing and avoid deterioration of the wound which could result in partial or complete amputation of the limb.

Interview with Transport Staff on 04/29/21 at 11:11am revealed:
-He "probably" did not back up enough to let Resident #1 out of the minivan.
-He "usually" pulled up to the lower ramp to let Resident #1 out, because the lower ramp had less of an incline making it easier to push the wheelchair up the ramp.
-The resident "helps me out around here."
-The resident was not required to "help" but was "paid" for "helping out."

b. Observation of Resident #1's room on 04/29/21 at 10:49am revealed:
-There was a bedside commode at the foot of the resident's bed.
-The bedside commode had a bedpan with a snap on lid as the waste collection container.
-There was a small plastic trash can which sat on top of the closed lid of the bedside commode.

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C 311	Continued From page 28 Interview with Resident #1 on 04/29/21 at 10:50am revealed: -At night, if the urge to urinate "hits me right, I'll be peeing in the floor." -He used the small trash can sitting on top of his bedside commode next to his bed to urinate into at night. -It was easier for him to grab the trash can to use than getting up to the bedside commode. -It was "easier" for him to "dump" the trash can and "rinse it out." -It was difficult for him to remove the snap on lid on the bedpan in the bedside commode to be able to use it. -It was difficult for him to empty and clean the bedside commode after he used it. -Staff did not empty and clean the bedside commode when he used it. -"We don't have a good nurse here." -"If I poop in there, I have to put the lid on it or it will be stinking." -He had "ordered" toilet paper and he had "not seen it yet." Interview with the Relief Supervisor-In-Charge (SIC) on 04/29/21 at 10:30am and 11:10am revealed: -She worked in the facility during the week in the day time until 2:00pm to help the Administrator "keep up" the resident charts and to clean the facility. -She did not empty or clean Resident #1's bedside commode. Interview with the Transport Staff on 04/29/21 at 11:11am revealed: -Resident #1 "usually" wheeled into the bathroom. -Resident #1 did not use the bedside commode. Interview with the Administrator on 04/28/21 at	C 311		

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C 311	Continued From page 29 1:55pm revealed: -Resident #1 had a bedside commode in his room. -Resident #1 would not use the bedside commode. -Resident #1 would urinate and defecate on himself when he slept. -She did not know where to buy incontinent briefs for a male. -None of Resident #1's health care providers had ever offered Resident #1 assistance to get incontinent briefs. c. Interview with Resident #1 on 04/29/21 at 10:50am revealed he did not have incontinent briefs to use. Interview with the Administrator on 04/28/21 at 1:55pm revealed: -Resident #1 urinated and defecated on himself daily when he slept. -She had to wash his clothes and bed linens daily. -She did not know where to buy incontinent briefs for a male. -None of Resident #1's health care providers had ever offered Resident #1 assistance to get incontinent briefs. Interview with the Relief Supervisor-In-Charge (SIC) on 04/29/21 at 10:30am and 11:10am revealed: -She did not know Resident #1 was incontinent of bladder and bowel. -She was aware Resident #1 had "accidents every now and again" during the day. -Resident #1 was unable to make it to the bathroom "sometimes" during the day. -The Administrator was Resident #1's full-time caregiver.	C 311		

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C 311	Continued From page 30 -She would "see what she could do" to obtain incontinent supplies for Resident #1. 2. Review of Resident #4's current FL2 dated 01/21/21 revealed diagnoses included paranoid schizophrenia, mild mental retardation, hypothyroidism, obesity, and tobacco abuse. Review of Resident #4's Resident Register revealed an admission date of 03/03/21. Interview with Resident #4 during initial tour on 04/27/21 at 8:53am revealed: -The dogs in the facility really bothered her. -She feared some of the dogs. Interview with Resident #4 on 04/28/21 at 9:23am revealed: -None of the facility dogs had ever been in her room. -She did not come out of her room except to smoke because she was scared of the dogs. Interview with the Administrator on 04/28/21 at 10:18am revealed: -She owned the 3 dogs that came in and out the house. -All the dogs had their rabies shots. -No resident has ever told her they were fearful of the dogs. -None of these dogs had ever tried to bite any of the residents. -She let everyone know before they move in that there are dogs in and around the facility. -Resident #4 never came out of her room. -Resident #4 never showed any interest in any of the dogs. -She did not know what she would do if someone feared the dogs.	C 311		

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C 311	Continued From page 31 Review of rabies vaccination records revealed all three dogs were currently up to date on their vaccines. Interview with a Supervisor in Charge (SIC) from a neighboring facility (sister house) on 04/28/21 at 4:01pm revealed: -She knew Resident #4 was afraid of some of the dogs. -None of the dogs had ever bothered Resident #4. Interview with the Guardian for Resident #4 on 04/29/21 at 9:33am revealed -Resident #4 was "terrified" of the dogs. -On the day she moved Resident #4 to the facility, one of the brown dogs "nipped" the Guardian's leg but she had jeans and boots on, so there was no injury. -She visited the facility on 04/22/21 and Resident #4 told her she was scared of the dogs and wanted to move back home. Interview with a 2nd SIC on 04/29/21 at 10:10am revealed: -She was not aware that one of the dogs had tried to bite Resident #4's Guardian. -The staff knew Resident #4 was afraid of dogs because the Guardian had told them before she came to live at the facility. -"We always kept the dogs away from her and away from her room." 3. Review of Resident #5's current FL2 dated 02/10/21 revealed diagnoses included schizoaffective disorder, manic suspect borderline intellect, and a history of gastoesophageal reflux disease. a. Interview with Resident #5 on 04/27/21 at	C 311		

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C 311	Continued From page 32 8:58am revealed: -The Relief Transport staff charged her "$5 or $10" to take her to appointments or to the store. -She could not afford to pay $5 or $10. -The Relief Transport staff said the money was to pay for gas. -She liked it better when the regular transport staff took her to her appointments because they never charged her. -She had given the Relief Transport staff $100 on 04/12/21 to take her to an appointment to get a COVID-19 vaccine. -The Relief Transport staff would refuse to take the resident if she did not pay for it. -The Relief Transport staff also charged other residents $5 or $10 to be taken to the store. Observation outside the facility on 04/28/21 at 2:57pm revealed: -The Relief Transport Staff drove up in a minivan in front of the facility to drop off a resident she had taken for an appointment. -A resident from a sister family care home on property asked the Relief Transport Staff if she could take him to the store. -"I'll give you gas money," the resident offered. -The Relief Transport Staff responded she had an appointment and could not take him to the store at that time. Interview with the Transport Staff on 04/28/21 at 10:57am revealed: -He never charged residents to take them to appointments or to go to the store. -He knew there was "one resident" who would offer money for transport, but he knew "we are not supposed to take it." Telephone interview with the Relief Transport Staff on 04/28/21 at 11:14am revealed:	C 311		

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-There was no charge to take residents to their appointments or to the store.
-When residents needed to go to the store, she would take them.
-Some of the residents would "offer $5" to go to the store, a local discount store, or a gas station.
-"I usually don't take the money."
-Some of the residents would offer her money for a trip to the store.
-One resident had actually left money in the van for a trip to the store.

Telephone interview with the Relief Transport Staff on 04/30/21 at 9:38am revealed:
-Resident #5 had offered her $100 for "several days" for taking Resident #5 to get a COVID-19 vaccine.
-She had refused to take the $100 "numerous times."
-Resident #5 had told her she wanted her to take the $100 to "buy something nice" for her children.
-At that point, she took the $100 Resident #5 offered her, but she had not yet spent it.

Interview with the Administrator on 04/28/21 at 1:55pm revealed:
-She did not know anything about staff charging resident's $5 or $10 for gas money to be taken to the store.
-She knew the Transport Staff did not charge residents to be taken to their appointments or be taken to the store.
-The facility policy was not to charge residents to be taken to their appointments or to be taken to the store.

Telephone interview with Resident #5's Guardian on 04/29/21 at 10:00am revealed:
-Resident #5 had not told her anything about paying gas money to be taken to the store or

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appointments.
-"I would not be ok" with Resident #5 paying to be taken to the store or appointments.
-She had not seen "anything in writing" from the facility about charging to take residents to the store or appointments.

b. Interview with Resident #5 on 04/27/21 at 8:58am revealed:
-She was unable to wash clothes on her assigned wash day, because the Administrator washed another resident's clothes and bed linens everyday.
-When the Administrator did allow her access to do her laundry, she was limited to wash four outfits at a time.
-She preferred to be allowed to wash all of her clothes on her laundry day.
-She did not feel it was fair because she was limited on what she was allowed to wash on her assigned laundry day.

Observation of Resident #5's room on 04/27/21 at 9:00am revealed there were two full laundry baskets of dirty clothes in the floor on the right of the entrance to the room.

Observation of the facility hallway on 04/27/21 at 9:20am revealed the washer and dryer were in use.

Interview with the Administrator on 04/28/21 at 1:55pm revealed:
-She normally did laundry for about 2 hours everyday.
-Washing clothes caused the water pressure in the men's common bathroom to drop.
-Resident #5 did her own laundry.
-Resident #5 could do laundry "anytime" she wanted too.

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C 311	Continued From page 35 -She liked for the residents to be done with the laundry before 5pm each day. -Resident #5 was not limited on how much laundry she could wash on her laundry day. -Resident #5 was in "this stage" where she just did one load a day. -No one had said anything to Resident #5 about limiting the amount of laundry she washed. Telephone interview with Resident #5's Guardian on 04/29/21 at 10:00am revealed: -Resident #5 did not share "the laundry issue" with her. -She had last seen Resident #5 on 04/22/21 and the resident had not indicated anything was wrong to her at that time. _____ The failure of the facility to ensure resident rights were maintained related to failure to provide assistance to Resident #1, who was put at an increased risk of left lower limb amputation due to being required to bear weight on his left foot to get up the facility ramp in his wheelchair upon return from an appointment; Resident #4 being afraid to come out of her room due to fear of facility animals, and Resident #5 being exploited by being required to pay to be taken to the store and appointments by one staff member and unable to do laundry on assigned laundry day which resulted in substantial risk of serious injury, neglect, and exploitation and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/29/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 2, 2021.	C 311		

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C 327	10A NCAC 13G .1003 (e) Medication Labels 10A NCAC 13G .1003 Medication Labels (e) Medications, prescription and non-prescription, shall not be transferred from one container to another except when prepared for administration to a resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to keep dispensed medications in original packaging for 1 of 3 sampled residents (Resident #3) related to transferring different medications from their original dispensed packaging to a medication organizer. The findings are: Review of Resident #3's current FL2 dated 02/10/21 revealed: -Diagnoses included shortness of breath, benign prostatic hypertrophy, hypotension, depression, and hypothyroidism. -There were orders for 10 prescription medications. Review of Resident #3's subsequent medication orders revealed there were orders for 2 additional prescription medications. Review of Resident #3's April 2021 Medication Administration Record (MAR) revealed: -Synthroid, Flomax, desmopressin, montelukast sodium, diltiazem ER, dutasteride, Effexor XR scheduled daily at 8:00am had been documented as administered from 04/01/21 to 04/22/21.	C 327		

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-Rabeprazole 20mg 1 tablet twice daily before meals at 7:00am and 4:30pm had been documented as administered from 04/01/21 to 04/22/21.
-Pantoprazole and tolterodine scheduled twice daily at 8:00am and 8:00pm had been documented as administered from 04/01/21 to 04/22/21.
-Melatonin scheduled daily at 8:00pm had been documented as administered from 04/01/21 to 04/22/21.

Interview with the Administrator on 04/27/21 at 8:30am and 11:15am revealed:
-Resident #3 had left on a trip to another state on 04/23/21.
-Resident #3 was supposed to return to the facility on 05/02/21.
-She had repackaged all of Resident #3's scheduled medications in a "pill sorter to take with him."
-She did not know medications needed to be repackaged by a pharmacy.

Observation of Resident #3's available medications on 04/27/21 at 3:29pm revealed:
-The following medications were available for administration: amlodipine, acetaminophen, Synthroid, Effexor, Flomax, tolterodine, montelukast sodium, finasteride (used to shrink enlarged prostate), famotidine (used to treat gastroesophageal reflux disease), Rabeprazole (used to treat gastroesophageal reflux disease), and atorvastatin (used to treat high cholesterol).
-The medications were in their original containers from the dispensing pharmacies.

Telephone interview with Resident #3 on 05/03/21 at 8:41am revealed:
-He had returned back to the facility late on

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C 327	Continued From page 38 04/30/21. -He had taken his medications with him for his trip. -The Administrator had packaged his scheduled prescription medications for his trip in a "day of the week" medication organizer with "AM and PM dividers."	C 327		
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: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 3 of 4 sampled residents (Residents #2, #3, and #4) related to medications for treating anxiety (#4), gastroesophageal reflux (#2), blood pressure (#3), high cholesterol (#3), and insomnia(#3). The findings are:	C 330		

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C 330	Continued From page 39 1. Review of Resident #4's current FL2 dated 01/21/21 revealed diagnoses included paranoid schizophrenia, asthma and tobacco abuse. Review of the Resident Register for Resident #4 revealed an admission date of 03/03/21. Review of physician's orders dated 03/03/21 for Resident #4 revealed an order for Lorazepam (a medication used to treat anxiety) 0.5 milligram (mg) tablet by mouth four times daily at 8:00am, 12:00pm, 4:00pm, and 8:00pm. Review of Resident #4's Medication Administration Record (MAR) for April 2021 revealed: -There was an entry for Lorazepam documented as given to Resident #4 on 04/21/22 at 8:00pm. -Circles were written in for the administration of Lorazepam for all four scheduled doses from 04/22/21 through 04/28/21 and for the two scheduled doses on 04/29/21. -On 04/22/21, the pharmacy was called for refills, but they were waiting on the refill request from the physician. -On 04/23/21, the facility continued to wait on refills and the pharmacy was notified. -On 04/24/21, the facility called the pharmacy and they are waiting on refills." -On 04/24/21 staff documented "resident goes to the doctor on the 30th." -On 04/26/21, the facility was still waiting on refills and the pharmacy had been notified. Telephone interview with the facility's contracted Pharmacist on 04/29/21 at 3:38pm revealed: -Lorazepam 0.5mg tablets four times daily was filled 03/03/21. -The quantity sent on 03/03/21 would have lasted until 04/22/21.	C 330		

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C 330	Continued From page 40 -The pharmacy had contacted the Nurse Practitioner (NP) for a new prescription. -As of 04/29/21, the pharmacy had yet to receive a new prescription from the NP. -The facility had not requested an emergency supply of Lorazepam, which is 3 days of medication, until they could get the prescription from the NP. -A new script from the NP had not been received as of 04/29/21. Interview with the Administrator on 04/29/21 at 3:02pm revealed: -Resident #4 had been out of her Lorazepam "for a week." -She did not have a physician to prescribe it for her. -Resident #4's Guardian was taking Resident #4 to see a physician on 04/30/21 and hopefully Resident #4 can get a refill. -She contacted the pharmacy to let them know Resident #4 was out of her Lorazepam. Interview with Resident #4's NP on 04/29/21 at 4:05pm revealed: -This facility had made no appointment for Resident #4 to return to see him. -It was the facility's duty to ensure Resident #4 was seen by a Primary Care Provider (PCP). -No one had called him to request any medication presecriptions or refills for Lorazepam. -Resident #4 had missed 30 doses of the Lorazepam. -She could have had an acute withdrawal with seizures. -He was very concerned about the medication administration of her Lorazepam or the "lack thereof." 2. Review of Resident #2's current FL2 dated	C 330		

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C 330	Continued From page 41 03/03/21 revealed diagnoses included reflux disease and peptic ulcer disease. Review of physician's orders dated 03/03/21 for Resident #2 revealed an order for famotidine (medication used to treat reflux disease) 20 milligrams (mg) twice a day. Review of the Medication Administration Record (MAR) for March 2021 revealed famotidine had not been transcribed to the MAR. Review of the MAR for April 2021 revealed: -An entry for famotidine 20mg twice a day was started on 04/01/21. -Famotidine was documented as administered twice a day from 04/01/21 thorugh 04/30/21. Telephone interview with the facility's contracted Pharmacist on 04/27/21 at 2:00pm revealed: -They received a request on 03/03/21 for Famotidine 20mg twice daily from the facility. -A 30-day supply, which was 60 capsules, was sent was delivered to the facility on 03/04/21. -The famotidine was signed for and received by the Transport Aide on 03/04/21. Interview with the Supervisor-In-Charge (SIC) on 04/27/21 at 2:14pm revealed: -She did not know why the Famotidine was not started for Resident #2 until 04/01/21. -The medication should have been started once it was received from the pharmacy. Interview with the Administrator on 04/27/21 at 2:17pm revealed: -She does not know why the Famotidine was not started until 04/01/21. -The Famotidine should have been started when it was received from the pharmacy on 03/04/21.	C 330		

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C 330	Continued From page 42 3. Review of Resident #3's current FL2 dated 02/10/21 revealed diagnoses included shortness of breath, benign prostatic hypertrophy, hypotension, depression, and hypothyroidism. a. Review of Resident #3's primary care physician (PCP) order dated 02/17/21 revealed: -Diltiazem ER (used to treat high blood pressure) 120mg 1 capsule daily. -The quantity was for 30 capsules. -The prescription was written with 5 refills. Review of Resident #3's Veteran's Administration (VA) health summaries active medication list dated 03/18/21 revealed: -Diltiazem ER was not listed as an active medication. -The list of medications were not signed by a physician. Review of Resident #3's February 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for diltiazem ER 120mg 1 capsule every day scheduled at 8:00am. -The diltiazem ER was documented as administered daily from 02/18/21 to 02/26/21. Review of Resident #3's March 2021 MAR revealed: -There was an entry for diltiazem ER 120mg 1 capsule every day scheduled at 8:00am. -The diltiazem was documented as administered from daily 03/01/21 to 03/14/21 and daily from 03/27/21 to 03/31/21. -On 03/15/21, there was a handwritten asterisk in the initial box with a hand written note below "order changed."	C 330		

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C 330	Continued From page 43 -The diltiazem was documented as not administered from 03/15/21 to 03/26/21. Review of Resident #3's April 2021 MAR revealed: -There was an entry for diltiazem ER 120mg 1 capsule every day scheduled at 8:00am. -The diltiazem was documented as administered daily from 04/01/21 to 04/22/21. Observation of Resident #3's medications on hand on 04/27/21 at 3:29pm revealed there was no diltiazem available. Interview with the Administrator on 04/27/21 at 2:50pm revealed Resident #3 received medication supplies from the VA, from the contracted facility pharmacy, and a local pharmacy. Telephone interview with the VA on 04/28/21 at 9:15am revealed: -Resident #3 had notified them on 03/03/21 that his PCP would no longer be sending prescriptions to the VA to be filled. -Resident #3's health summaries active medication list dated 03/18/21 was not orders for medications, but the medications the VA supplied to the resident. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/28/21 at 3:09pm revealed: -They had received an electronic prescription from Resident #3's physician for diltiazem ER 120mg 1 capsule daily. -They sent out a 17-day supply of diltiazem for Resident #3 on 02/25/21. -They had not sent any additional diltiazem for Resident #3 since 02/25/21.	C 330		

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C 330	Continued From page 44 -Resident #3 was not on "cycle fill with us." -The VA provided Resident #3's medications. Telephone interview with Resident #3 on 05/03/21 at 8:41am revealed: -He was not sure what the diltiazem had been prescribed to treat. -He did not know if he had recently been taking it or not. b. Review of Resident #3's current FL2 dated 02/10/21 revealed an order for amlodipine (used to treat hypertension) 5mg 1 tablet daily. Review of Resident #3's physician's order dated 02/17/21 revealed discontinue amlodipine. Review of Resident #3's Veteran's Administration (VA) health summaries active medication list dated 03/18/21 revealed: -Amlodipine was listed as an active medication. -The list of medications was not signed by a physician. Review of Resident #3's February 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amlodipine 5mg 1 tablet every day scheduled at 8:00am. -The amlodipine was documented as administered daily from 02/01/21 to 02/18/21. Observation of Resident #3's available medications on 04/27/21 at 3:29pm revealed: -There was one bottle of amlodipine 10mg tablets filled by the VA. -The amlodipine had been filled on 01/25/21 with a quantity of 45 tablets with 3 refills remaining. -There were 17 whole tablets and 5 1/2 tablets remaining in the bottle.	C 330		

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C 330	Continued From page 45 Interview with the Administrator on 04/27/21 at 3:45pm revealed: -She did not know there was an order to discontinue the amlodipine for Resident #3 written on 02/17/21. -She had continued to administer the amlodipine. Attempted interview with Resident #3's primary care physician on 04/28/21 at 3:38pm was unsuccessful. c. Review of Resident #3's current FL2 dated 02/10/21 revealed there was no order for atorvastatin (used to treat high cholesterol). Review of Resident #3's Veteran's Administration (VA) health summaries active medication list dated 03/18/21 revealed: -Atorvastatin 20mg take 1/2 tablet daily at bedtime was listed as an active medication. -The list of medications was not signed by a physician. Review of Resident #3's February 2021 electronic Medication Administration Record (eMAR) revealed: -There was no entry for atorvastin 20mg take 1/2 tablet daily at bedtime. -There were no documented administrations of atorvastatin. Review of Resident #3's February through April 2021 paper Medication Administration Record (MARs) revealed: -There were no entries for atorvastatin 20mg take 1/2 tablet daily at bedtime. -There were no documented administrations of atorvastatin on the MARs.	C 330		

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Observation of Resident #3's medications on hand 04/27/21 at 3:29pm revealed:
-There was one bottle of atorvastatin 20mg tablets filled by the VA.
-The atorvastatin had been filled on 01/25/21 with a quantity of 45 tablets with 3 refills remaining.
-There were 4 tablets of atorvastatin remaining in the bottle.

Review of Resident #3's record revealed:
-The 45 tablets of atorvastain 20mg tablets filled by the VA on 01/25/21should have provided a 90 supply for Resident #3.
-If the atorvastatin had been discontinued as ordered on 02/10/21, there would have been 37 and 1/2 tabs remaining of the atorvastin on hand.

Interview with the Administrator on 04/27/21 at 3:45pm revealed:
-She did not know the atorvastin had been discontinued on the FL2 dated 02/10/21.
-If the atorvastatin was in with Resident #3's other medications, then she had continued to administer it to the resident.

Telephone interview with Resident #3 on 05/03/21 at 8:41am revealed:
-He was not sure if he had recently been taking medication to reduce his cholesterol levels.
-The last time he had his cholesterol checked his "good and bad cholesterol" and triglycerides had been "fine."

Attempted interview with Resident #3's primary care physician on 04/28/21 at 3:38pm was unsuccessful.

d. Review of Resident #3's current FL2 dated 02/10/21 revealed there was an order for melatonin (used to treat insomnia) 3mg 1 tablet at

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C 330	Continued From page 47 bedtime. Review of Resident #3's Veteran's Administration (VA) health summaries active medication list dated 03/18/21 revealed: -Melatonin was not listed as an active medication. -The list of medications were not signed by a physician. Review of Resident #3's February 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for melatonin 3mg 1 tablet at bedtime. -The melatonin was documented as administered daily at 8:00pm from 02/01/21 to 02/28/21. Review of Resident #3's February through March 2021 paper Medication Administration Record (MARs) revealed: -There were no entries for melatonin. -There were no documented administrations of melatonin on the MARs. Review of Resident #3's April 2021 MAR revealed: -There was an entry for melatonin 3mg 1 tablet at bedtime. -The melatonin was documented as administered daily at 8:00pm from 04/01/21 to 04/22/21. Observation of Resident #3's medications on hand 04/27/21 at 3:29pm revealed there was no melatonin available. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/27/21 at 2:55pm revealed: -The pharmacy had received an order for melatonin 3mg 1 tablet at bedtime dated	C 330		

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C 330	Continued From page 48 01/15/21. -The melatonin was continued on the FL2 dated 02/10/21. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 04/28/21 at 3:09pm revealed: -Resident #3 was not on "cycle fill with us." -The VA provided Resident #3's medications. Telephone interview with the VA on 04/28/21 at 9:15am revealed Resident #3 had notified them on 03/03/21 that his PCP would no longer be sending prescriptions to the VA to be filled. Telephone interview with Transport Staff on 04/30/21 at 1:40pm revealed the Administrator compared the medication orders, to the medications on hand, to the printed MARs received from the contracted pharmacy each month. Attempted interview with Resident #3's primary care physician on 04/28/21 at 3:38pm was unsuccessful. _____ The facility failed to ensure medications were administered as ordered related to anxiety medication (#4), gastroesophageal reflux disease medication (#2), two blood pressure medications (#3), high cholesterol medication, and medication to treat insomnia (#3) resulted in increased risk of Resident #4 having experienced acute withdrawal with seizures after missing 30 doses of anxiety medication .The facility's failure placed the residents at substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/27/21 for	C 330		

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C 330	Continued From page 49 this violation.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of medication administration records for 3 of 4 sampled residents (Residents #1 and #4), including medications used to treat insomnia (#4) and a liquid protein to promote wound healing (#1). The findings are:	C 342		

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C 342	Continued From page 50 2. Review of Resident #1's current FL2 dated 04/23/21 revealed diagnosis included hypertension, stage 3 chronic kidney disease, delusional disorder, ulcer of the left foot, and hypothyroidism. Review of Resident #1's rehabilitation facility discharge summary dated 02/13/21 revealed: -The primary admission diagnosis was acute osteomyelitis of the left ankle and foot. -There was an order for Pro-Stat Sugar Free (complete liquid protein clinically supported to promote wound healing) 30ml by mouth daily for wound healing. Review of Resident #1's February 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Pro-Stat Sugar Free take 30ml every day for wound healing starting 02/16/21 to 02/26/21 scheduled at 8:00am. -The Pro-Stat Sugar Free was documented as not administered on 02/16/21 due to "resident refused." -The Pro-Stat Sugar Free was documented as administered daily at 8:00am from 02/17/21 to 02/26/21. Review of Resident #1's March 2021 paper Medication Administration Record (MAR) revealed: -There was an entry for Pro-Stat Sugar Free take 30ml every day for wound healing scheduled at 8:00am. -The Pro-Stat Sugar Free was documented as administered daily at 8:00am from 03/01/21 to 03/31/21. Review of Resident #1's April 2021 MAR	C 342		

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C 342	Continued From page 51 revealed: -There was an entry for Pro-Stat Sugar Free take 30ml every day for wound healing scheduled at 8:00am. -The Pro-Stat Sugar Free was documented as administered daily at 8:00am from 04/01/21 to 04/27/21. Observation of Resident #1's Pro-Stat Sugar Free on 04/27/21 at 4:20pm revealed: -The grape flavored Pro-Stat Sugar Free was in a 30 fluid ounce bottle (887 ml.). -The bottle was open and almost completely full. Interview with the Administrator on 04/27/21 at 4:21pm revealed: -Resident #1 had refused to take the Pro-Stat Sugar Free as it was ordered. -She had documented on the February, March, and April MARs the resident had taken it, however the resident had refused it each time she offered it to him. 3. Review of Resident #4's current FL2 dated 01/21/21 revealed diagnoses included paranoid schizophrenia and mild mental retardation. Review of the physician's order for Resident #4 dated 03/03/21 revealed Melatonin 5 mg take one tablet by mouth at bedtime. Review of Resident #4's Medication Administration Record (MAR) for March 2021 revealed there was no entry for administration of Melatonin 5mg tablet at 8:00pm from 03/18/21 - 03/31/21. Review of Resident #4's MAR for April 2021 revealed there was no entry for administration of	C 342		

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C 342	Continued From page 52 Melatonin 5mg tablet at 8:00pm from 04/02/21 - 04/28/21. Interview with the Administrator on 04/29/21 at 3:02pm revealed: -She administered all medications to Resident #4. -She could not explain why she did not document on the March 2021 MAR from 03/18/21 - 03/31/21 that Melatonin was administered to Resident #4. -She could not explain why she did not document on the April 2021 MAR from 04/02/21 - 04/28/21 that Melatonin was administered to Resident #4. -Medications are being given to Resident #4 "every night." -"I just forgot to sign off on it."	C 342		
C 601	10A NCAC 13G .1701 (a) (b) Infection Prevention & Control Program (emer) 10A NCAC 13G .1701 Infection Prevention and Control Program (a) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services. This Rule is not met as evidenced by:	C 601		

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C 601	Continued From page 53 Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to provide protection to the residents and to reduce the risk of transmission and infection as related to the facility's use of masks as personal protective equipment (PPE) by staff and residents. The findings are: Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility revealed: -Staff should wear a facemask at all times while they are in the facility. -Residents should wear a cloth face covering or facemask anytime they leave their rooms. -Appropriate PPE should be used by personnel when in contact with the resident. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed: -Facility staff should wear appropriate PPE when caring for patients with undiagnosed respiratory infection or confirmed COVID-19. -Facility staff should wear all recommended PPE, including a surgical mask or N95 mask, gown, gloves and face shield when caring for all residents whether they have tested positive for COVID-19 or not. Review of the facility's Infection Control Policy	C 601		

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	FCL011022	A. BUILDING: _____ B. WING _____	R-C 05/03/2021

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C 601	Continued From page 54	C 601		

revealed staff were required to wear facemasks as a barrier to help prevent respiratory droplets from traveling in the air.

Observation upon entrance to the facility on 04/27/21 at 8:30am revealed:
-The Transport Staff came out of the front door of the facility and greeted the surveyors without wearing a facemask.
-The surveyors were told to enter the facility, check their temperatures at the wall mounted infrared thermometer, and fill out a COVID-19 screening questionnaire.

Observation in the hallway outside the last resident room on the right on 04/27/21 at 9:25am revealed:
-A child was standing in the hallway outside the resident room.
-The child was not wearing a mask.

Interview with a resident on 04/27/21 at 9:30am revealed:
-The child was the grand child of the Administrator.
-The child did not reside in the facility.
-The child was eight or nine years old.
-The child was out of school for the day due to illness.
-The staff did not wear their face masks in the house all the time.

Interview with a third resident on 04/27/21 at 9:23am revealed:
-The Administrator had not been wearing a face mask in the facility.
-The Transport Staff had not been wearing a face mask in the facility.
-When some of the Administrator's family members have visited, they have not been

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C 601	Continued From page 55 wearing masks. Observation in the facility living room on 04/27/21 at 10:00am revealed the Transport Staff was not wearing a face mask. Observation of the Administrator on 04/27/21 at 10:18am revealed the Administrator was standing in the kitchen with a face mask on, but it was pulled down below her nose. Interview with the Administrator on 04/27/21 at 10:18am revealed: -She and the Transport Staff had asked their physician for an order indicating they did not have to wear a face mask since they both have diagnoses that make breathing difficult through a face mask. -The Physician's Office informed them they would need to make an appointment to see the physician to have this done. -She has yet to make an appointment to see the physician. Observation in the facility dining room on 04/27/21 at 1:45pm revealed: -The Administrator's grand child was in the dining room talking to a resident who was not wearing a face mask. -The child was not wearing a face mask and was not maintaining social distance. Observation in the facility dining room on 04/27/21 at 4:10pm revealed: -A second grand child came into the dining room and hugged the Relief Supervisor-In-Charge (SIC) who wore a face mask. -The child was not wearing a face mask. Interview with the Relief SIC on 04/28/21 at	C 601		

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C 601	Continued From page 56 10:41am revealed: -4 of 6 residents had received both vaccinations for COVID-19. -1 of 6 residents had received one vaccination for COVID-19. -1 of 6 residents had refused the offer to receive the COVID-19 vaccinations. -The Transport Staff had received both vaccinations for COVID-19. -The Administrator had not received the COVID-19 vaccinations. Interview with the Transport Staff on 04/28/21 at 11:20am revealed: -"Half the time" he did not wear a face mask. -He and the Administrator both had chronic obstructive pulmonary disease and mask made it difficult to breathe. -He also had been diagnosed with asthma. -The grand children who visited the facility "should be wearing" face masks when they were inside the building. Interview with the Administrator on 04/28/21 at 1:55pm revealed: -Her grand children had to werar masks to school and when riding the school bus, but when they got to the facility they would take the face masks off. -"If we are wearing masks, the grand kids will wear them."	C 601		
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	C 912		

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C 912	Continued From page 57 regulations. This Rule is not met as evidenced by: Based on 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 and regulations related to medication administration and tuberculosis testing. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 3 of 4 sampled residents (Residents #2, #3, and #4) related to medications for treating anxiety (#4), gastroesophageal reflux (#2), blood pressure (#3), high cholesterol (#3), and insomnia(#3).[Refer to Tag 0330, 10A NCAC 13G .1004(a) Medication Administration (Unabated Type A2 Violation)]. 2. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled residents (Residents #1 and #3) had completed tuberculosis (TB) testing upon admission. [Refer to Tag 0212 10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination (Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by:	C 914		

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C 914	Continued From page 58 Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect related to resident rights, personal care and supervision, and health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure resident rights were maintained for 3 of 5 residents sampled (Resident #1, #4, and #5) for not emptying a bed side commode and providing briefs and toileting assistance and not providing assistance from a vehicle into the facility (#1), addressing a resident's fear of facility animals (#4), and residents paying staff to take them to the store and having access to do laundry (#3).[Refer to Tag 0311 10A NCAC 13 G .0909 Resident Rights (Type A2 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 1 sampled residents (Resident #4) who needed smoking supervision. [Refer to Tag 0243 10A NCAC 13G .0901(b) Personal Care and Supervision (Type B Violation)]. 3.Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the routine and acute health care needs of 2 of 4 residents related to a psychiatric referral (#4), wound care orders (#1), and a protein supplement refusal (#1).[Refer to Tag 0246 10 A NCAC 13G .0902(b) Health Care (Type A1 Violation)].	C 914		