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FAIRVIEW FAMILY CARE HOME # 1	256 GRAVELY BRANCH ROAD FLETCHER, NC 28732

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C 000	Initial Comments The Adult Care Licensure Section completed a follow-up survey initiated on 06/18/21 with an onsite visit, desk review on 06/21/2021, an onsite visit on 06/23/21, desk review on 06/24/21 through 06/25/21 and a telephone exit on 06/25/21.	C 000		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews and interviews the Administrator failed to ensure the management and total operations of the facility were maintained to ensure compliance with the rules and statutes of adult care homes to protect each resident's rights to receive adequate and appropriate care and services and to be free of neglect as related to resident supervision,	C 185		

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healthcare referral, medication administration, maintaining a controlled substance count sheet and infection prevention.

The findings are:

Interview with the Administrator on 06/23/21 at 12:40pm revealed:
-She did not know what medications she had administered to the residents.
-She did not know if each resident was getting the correct medications or not.

Interview with the Administrator and a supervisor-in-charge (SIC) at a sister facility on 06/25/21 at 1:26pm revealed:
-The Administrator was responsible for the day-to-day operations of the facility.
-The Administrator administered all medications in the facility and was responsible for maintaining and ensuring the accuracy of the facility's medication administration records.
-She was not comfortable completing controlled substance count sheets as she had never been trained.
-A family member was responsible for taking messages from the phone answering machine because she did not know how to do it.
-A family member made arrangements for resident appointments and informed her of the appointment dates and times.
-She relied on a former SIC from a sister facility for help with the operation of the facility and "had for a long time".

Non-compliance was identified in the following rule areas:

1. Based on observations, interviews and record reviews the facility failed to provide supervision to

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C 185	Continued From page 2 1 of 3 sampled residents (Resident #1) who needed supervision while smoking. [Refer to Tag 0243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Unabated Type B Violation)]. 2. Based on interviews and record reviews the facility failed to ensure acute healthcare needs were met for 1 of 3 sampled residents (Resident #1) related to a psychology referral for a resident exhibiting psychiatric symptoms. [Refer to Tag 246, 10A NCAC 13G .0902(b) Health Care (Unabated Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to contact the primary care physician (PCP) for 1 of 3 sampled residents (Resident #2) related to clarification of medication orders for a medication to treat benign prostatic hyperplasia (BPH) and a medication used to treat acid reflux. [Refer to Tag 0315, 10A NCAC 13G .1002(a) Medication Orders (Standard Deficiency)]. 4. Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 2 of 3 sampled residents (Residents #1 and #2) related to a medication to treat anxiety associated with schizophrenia (Resident #1) and medications to treat benign prostatic hyperplasia (BPH) and acid reflux (Resident #2). [Refer to Tag 0330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]. 5. Based on record reviews interviews the facility failed to ensure the the staff who administered a medication was the same staff who documented the administration on the Medication Administration Record. [Refer to Tag 0341, 10A NCAC 13G .1004(i) Medication Administration	C 185		

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C 185	Continued From page 3 (Standard Deficiency)]. 6. Based on observations, interviews and record reviews the facility failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 3 sampled residents (Residents #1 and #2) related to a medication to treat anxiety (#1) and medications to treat benign prostatic hyperplasia (BPH) and acid reflux (#2). [Refer to Tag 0342, 10A NCAC 13G .1004(j) Medication Administration (Standard Deficiency)]. 7. Based on interviews and record reviews the facility failed to maintain accurate records of receipt and administration of a controlled substance on a Controlled Substance Count Sheet (CSCS) for 1 of 1 sampled resident (Resident #1) related to a medication to treat anxiety. [Refer to Tag 0367, 10A NCAC 13G .1008(a) Controlled Substances (Standard Deficiency)]. 8. Based on observations and interviews, 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 during the global Coronavirus (COVID-19) pandemic as related to COVID-19 screening of staff, visitors and residents. [Refer to Tag 0612, 10A NCAC 13G .1701(c) Infection Prevention (Standard Deficiency)]. The Administrator failed to ensure the management of the facility to maintain substantial compliance with the rules and statutes governing family care homes. The Administrator failed to ensure a resident was adequately supervised while smoking, resulting in the resident smoking in her bedroom and extinguishing the cigarettes	C 185		

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C 185	Continued From page 4 in flammable items; failed to obtain a healthcare referral for a resident who was exhibiting worsening psychological behaviors, failed to clarify medication orders related to prostate and reflux medications, failed to administer medications as ordered related to an anxiety, prostate, and reflux medication resulting in a resident having disrupted sleep due to frequent urination; failed to ensure medication administration records were accurate; failed to account for controlled substances and failed to follow guidelines related to infection prevention during a global pandemic. The Administrator's failures resulted in inadequate and inappropriate care of residents and serious neglect and constitutes a Type A1 Violation. _____ The facility failed to provide a plan of protection in accordance with G.S. 131D-34 by 06/25/21.	C 185		
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: FOLLOW-UP TO A TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews and record reviews the facility failed to provide supervision to 1 of 3 sampled residents (Resident #1) who needed supervision while smoking.	C 243		

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C 243	Continued From page 5 The findings are: Review of Resident #1's current FL2 dated 04/30/21 revealed diagnoses included paranoid schizophrenia, moderate intellectual disability and tobacco use. Review of Resident #1's Resident Register dated 03/03/21 revealed: -She was admitted to the facility on 03/03/21. -A notice of discharge was initiated by the administrator on 06/15/21 because Resident #1 was caught smoking in her bedroom multiple times and refused to follow the facility's smoking policy. -She was transferred to another facility on 06/17/21. Review of Resident #1's record revealed no assessment for smoking safety. Review of the Facility's Admission Policy & Procedure signed by Resident #1'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 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).	C 243		

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C 243	Continued From page 6 -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. Interview with two residents on 06/18/21 at 10:00am revealed: -Resident #1 smoked cigarettes in her room. -Resident #1 "hung out her window many times, bumming cigarettes and a lighter". -Resident #1 rarely came out of her room. Observation of Resident #1's bedroom on 06/18/21 at 10:12am revealed: -The room had a foul odor. -The carpet in the closet had multiple cigarette burn holes that contained cigarette ash. -The windowsill contained more than 50 cigarette burn marks. Interview with the Administrator on 06/18/21 at 9:55am revealed: -Resident #1 was discharged from the facility on 06/17/21 because she would not follow the smoking policy. -When she was admitted on 03/03/21 the guardian informed staff Resident #1 would need to be supervised when she was smoking because she had a history of smoking in her bedroom at her previous facility. -Resident #1 set off the smoke alarm two weeks ago at 1:30am when she was smoking in her room. -On 06/15/21 she took a breakfast tray to Resident #1 and when she entered the room, the room was smoky and Resident #1 was "hunkered down in her closet" with a lighter and an extinguished cigarette in her hand. -She confronted Resident #1 about the smoke in the bedroom but Resident #1 denied smoking.	C 243		

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-Resident #1 was instructed to smoke outside in an area designated for smoking but she did not always stay outside with her because other residents were outside and could monitor her.
-She did not collect the cigarette butts from Resident #1 when she was finished smoking outside.
-She cleaned Resident #1's bedroom once a week and "usually" found 1-3 cigarette butts in a wicker basket on her dresser. She did not confront Resident #1 about the cigarette butts because "I never fuss at people because it would do no good".
-Because Resident #1 should not have had access to cigarettes inside, she was not monitored.
-She did not know what else to do to prevent Resident #1 from smoking in her room.
-She was not able to take care of Resident #1 because she needed more supervision than the facility could provide.

Interview with 2 Supervisors-in-Charge (SIC) from sister facilities on 06/18/21 at 11:02am revealed:
-A few weeks ago, one of the SICs caught a resident from a sister facility lighting a cigarette for Resident #1 through her open window.
-Resident #1 had a lit cigarette in her hand when the SIC went inside to tell her she was not allowed to smoke inside.
-Resident #1 was known to lean out her window and ask anyone she could see on the facility's property to light her cigarettes.
-The SICs knew of three other residents who lived at nearby sister facilities who gave Resident #1 cigarettes and a lighter, even though they were instructed to not do that.
-The SICs, the Administrator and the guardian had all talked with Resident #1 about not smoking in her room, but nothing stopped her from

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continuing to do it.
-The guardian was aware of the smoking rules because she signed the smoking policy on 03/03/21 when Resident #1 was admitted to the facility.
-Per facility policy, Resident #1 was given three verbal warnings and three written warnings and then received a notice of discharge due to smoking in her room.
-They attempted to contact the guardian when the warnings were given.

Interview with a SIC from a sister facility on 06/18/21 at 11:16 revealed:
-She told the surveyor yesterday that Resident #1 was being discharged because she started a fire in her closet but what she really meant was Resident #1 was putting out her lit cigarettes in the dresser drawers, closet floor, incontinence briefs and windowsill; all areas that were flammable.
-There was not a "full fire"- just smoldering and melting incontinence briefs.
-Other than continuing to tell her to not smoke in her room, no other measures were put in place to stop her behaviors.

Review of Resident #1's record revealed:
-There were five handwritten notes dated and signed by Resident #1, the Administrator and a SIC from a sister facility.
-The note dated 05/02/21 documented Resident #1 was given a verbal warning due to smoking in her room.
-The note dated 05/11/21 documented Resident #1 was given a second verbal warning due to smoking in her room.
-The note dated 05/14/21 documented Resident #1 was given a third verbal warning due to smoking in her room and this note also served as

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C 243	Continued From page 9 her 1st written warning and they attempted to contact the guardian without success. -The note dated 05/27/21 documented Resident #1 was given a written warning about smoking in her room, documenting that the next time she was caught smoking in her room she would be immediately discharged; they attempted to contact the guardian without success . -The note dated 06/15/21 documented the guardian was given a 48-hour notice of discharge due to Resident #1 smoking in her room. Telephone interview with a representative from Resident #1's guardianship agency on 06/24/21 at 10:07am revealed: -The agency had been Resident #1's guardian since 09/22/2011 because she was deemed incompetent. -The agency was informed of the notice of discharge on 06/15/21 by the facility's Administrator and she was told Resident #1 needed to be transferred out of the facility by 06/17/21 at noon because Resident #1 was caught smoking inside the building multiple times and had been given both verbal and written notices. The facility failed to supervise Resident #1, who had a known history of smoking in her bedroom, resulting in Resident #1 continuing to smoke in her bedroom, extinguish cigarettes in flammable items causing them to smoke and smolder and putting the facility at risk of having a fire. This failure was detrimental to the safety of all residents residing in the facility and constitutes a Type Unabated B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/18/21.	C 243		

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C 246	Continued From page 10	C 246		
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 A1 VIOLATION Based on these findings, the previous Type A1 Violation was not abated. Based on interviews and record reviews the facility failed to ensure acute healthcare needs were met for 1 of 3 sampled residents (Resident #1) related to a psychology referral for a resident exhibiting psychiatric symptoms. The findings are: Review of Resident #1's current FL2 dated 04/30/21 revealed diagnoses included paranoid schizophrenia, moderate intellectual disability and tobacco use. Review of Resident #1's Resident Register dated 03/03/21 revealed she was admitted to the facility on 03/03/21. Review of Resident #1's record revealed there was no assessment for smoking safety. Telephone interview with a nurse from Resident #1's Primary Care Physician (PCP) on 06/25/21 at 1:37pm revealed: -Resident #1 was seen by the PCP on 04/30/21. -At that appointment a psychology referral was ordered because the PCP thought Resident #1	C 246		

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had psychological issues that could not be addressed by the PCP.
-The psychology provider called the facility three times, leaving messages on the answering machine for a return call.
-The psychology provider never received any return calls from the facility, so they sent a notice back to Resident #1's PCP on 05/28/21 stating they were unable to make contact.

Review of the Plan of Protection received on 04/28/21 from the 05/03/21 survey written for a healthcare referral for Resident #1 revealed:
-"Will have owner contact guardian to meet at ER (Emergency Room) for evaluation today (04/28/21)."
-"If no contact with guardian, will call sheriff's office for assistance to take resident to ER for evaluation."

Review of Resident #1's record revealed:
-There were five handwritten notes dated and signed by Resident #1, the Administrator and a SIC from a sister facility.
-The note dated 05/02/21 documented Resident #1 was given a verbal warning due to smoking in her room.
-The note dated 05/11/21 documented Resident #1 was given a second verbal warning due to smoking in her room.
-The note dated 05/14/21 documented Resident #1 was given a third verbal warning due to smoking in her room and this note also served as her 1st written warning and they attempted to contact the guardian without success.
-The note dated 05/27/21 documented Resident #1 was given a written warning about smoking in her room, documenting that the next time she was caught smoking in her room she would be immediately discharged; they attempted to

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contact the guardian without success .
-The note dated 06/15/21 documented the guardian was given a 48-hour notice of discharge due to Resident #1 smoking in her room.

Observation of Resident #1's bedroom on 06/18/21 at 10:13am revealed:
-The bedroom had a foul odor.
-The carpet in the closet had several holes from cigarette burns and one hole contained cigarette ash.
-Feces was smeared on two of the three walls in the closet.
-The windowsill contained more than 50 cigarette burn marks.

Interview with the Administrator on 06/18/21 at 3:24pm revealed:
-Resident #1's guardian was supposed to arrange for Resident #1 to be evaluated by psychology before she was admitted.
-She asked the guardian to obtain a psychology referral but the guardian never followed-up.
-She thought she could not obtain a psychology referral without the guardian's permission.
-Two weeks ago Resident #1 set off the fire alarm at 1:30am because she was smoking in her bedroom and it disrupted the entire home.
-Resident #1 was seen by her PCP on 04/30/2021 for a new patient appointment, to have an FL2 signed and to get prescriptions for medications.
-The guardian did not participate in the initial PCP visit as requested by the Administrator.
-She did not request a psychology referral because she thought the guardian was the only one who could request it.

Attempted review of Resident #1's progress notes and incident reports revealed there were no

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C 246	Continued From page 13 progress notes or incident reports available. Interview with two residents on 06/18/21 at 10:00am revealed: -Resident #1 smoked cigarettes in her room. -Resident #1 "hung out her window many times, bumming cigarettes and a lighter". -Resident #1 rarely came out of her room. Interview with the Administrator on 06/23/21 at 2:48pm revealed: -She never pursued a psychology referral because "that was the guardian's job". -She left a voice mail message for the guardian about the need for a psychology referral but the call was not returned for 2 weeks. -Resident #1 needed a psychology referral because she would deny smoking in her room when she had an extinguished cigarette in her hand, was smearing feces in her bedroom closet, smoking in her room against policy, setting off the fire alarm in the middle of the night, extinguishing cigarettes in the closet, the windowsill and her incontinence briefs and refusing to come out of her room. Interview with the Administrator and a supervisor-in-charge (SIC) at a sister facility on 06/25/21 at 1:26pm revealed a family member was responsible for taking messages from the phone answering machine because the Administrator did not know how to do it. _____ The facility failed to obtain a psychology referral for one resident which was ordered by her PCP on 04/30/21 and originally cited in a survey with exit date of 05/03/21 for Resident #1 who used her closet as a bathroom and smeared feces on the walls of her closet; she refused to come out of her room and constantly isolated herself;	C 246		

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C 246	Continued From page 14 continued to smoke inside the facility despite three verbal warnings and two written warning and extinguished her cigarettes on her incontinent briefs, the carpet, windowsill and set off the fire alarm in the middle of the night. This failure resulted in serious neglect and constitutes an Unabated Type A1 Violation. _____ The facility failed to provide a plan of protection in accordance with G.S. 131D-34 by 06/25/21.	C 246		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to contact the primary care physician (PCP) for 1 of 3 sampled residents (Resident #2) related to clarification of medication orders for a medication to treat benign prostatic hyperplasia (BPH) and a medication used to treat acid reflux.	C 315		

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C 315	Continued From page 15 The findings are: Review of Resident #2's current FL2 dated 02/10/21 revealed diagnoses included hypotension, depression, benign prostate hyperplasia (BPH) with urinary frequency, hypothyroidism, and shortness of breath. a. Review of Resident #2's current FL2 dated 02/10/21 revealed a physician's order for dutasteride (used to treat BPH) 0.5mg take 1 capsule daily. Review of a pharmacy delivery ticket for Resident #2 dated 01/22/21 revealed: -There were 90 tablets of finasteride 5 mg (used to treat BPH) take 1 tablet daily delivered to the facility on 01/22/21. -The directions on the medication label included a note that the medication "replaces dutasteride." -There was no explanation why the finasteride replaced the dutasteride. Review of Resident #2's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for dutasteride 0.5mg take 1 capsule daily scheduled to be administered at 8:00am daily. -The entry for dutasteride was crossed out with a handwritten note "changed to finasteride 01/22/21" with a question mark beside the date. -Dutasteride was documented as administered from 06/01/21 to 06/18/21 at 8:00am daily. -There was no entry for finasteride. Observation of Resident #2's medication on hand on 06/23/21 at 11:09am revealed: -There was no dutasteride 0.5mg available to be administered.	C 315		

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C 315	Continued From page 16 -There was a bottle of finasteride 5mg with a fill date of 06/10/21 available to administer. -The finasteride was not dispensed from the facility's contracted pharmacy. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 10:00am revealed: -On 6/16/21, 5 tablets of dutasteride 0.5mg were dispensed to Resident #2 as an emergency fill. -On 02/21/21, 17 tablets of dutasteride 0.5mg were dispensed to Resident #2. -The pharmacy did not have a current order with refills for dutasteride. -The pharmacy had never filled finasteride for Resident #2. Interview with Resident #2 on 06/23/21 at 3:30pm revealed: -He was having a hard time sleeping at night over the past month because he had to get up and go to the restroom so many times. -Some nights, he would have to get up 6 to 7 times to go to the restroom. Interview with a former supervisor-in-charge (SIC) at a sister facility on 06/23/21 at 12:05pm revealed: -She was responsible for clarifying medication orders for the residents in the facility. -Resident #2 was getting medications from three different pharmacies and seeing several different physicians. -Resident #2 got some of his medications filled at another pharmacy besides the facility's contracted pharmacy. -She tried to contact Resident #2's primary care provider last week but he was out of town and she could not get the order clarified. -She thought the finasteride was supposed to	C 315		

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replace the dutasteride because of the medication label but she did not have an order stating this.
-She did not know why the finasteride was supposed to replace the dutasteride.
-Resident #2 was not administered any medication to treat his BPH because the order was not clarified.

Telephone interview with a nurse from Resident #2's primary care provider's (PCP) office on 06/24/21 at 3:33pm revealed:
-Resident #2 was prescribed dutasteride to treat his BPH.
-Dutasteride was listed as an active medication for Resident #2.
-The PCP was responsible for refilling Resident #2's medication for BPH.
-The PCP had never prescribed finasteride to Resident #2.
-Resident #2 must have received the finasteride from another provider.

Interview with the Administrator on 06/23/21 at 3:03pm revealed:
-She reached out to a family member to help make sure the medication orders were correct.
-The former SIC did her best to keep the medication orders updated.
-The former SIC was working to get the orders clarified.
-She did not know what medications the residents were supposed to be administered.

b. Review of Resident #2's current FL2 revealed a physician's order for pantoprazole (used to treat heart burn) 40mg take 1 tablet twice daily.

Observation of Resident #2's medication on hand at 11:09am on 06/23/21 revealed:

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C 315	Continued From page 18 -There was no pantoprazole available to be administered. -There was a bottle containing rabeprazole 20mg take 1 tablet daily filled on 06/22/21 at Resident #2's pharmacy. -The rabeprazole was not filled by the facility's contracted pharmacy. Review of Resident #2's record on 06/23/21 revealed there was no physician's order for rabeprazole 20mg take 1 tablet daily. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 10:00am revealed: -The pharmacy last dispensed 34 tablets of pantoprazole 40mg to Resident #3 on 02/25/21. -The pharmacy had not received an order to discontinue the pantoprazole. -The pharmacy did not have a medication order for rabeprazole for Resident #3. Telephone interview with a pharmacist from Resident #2's pharmacy on 06/25/21 at 11:04am revealed the pharmacy dispensed 30 tablets of rabeprazole 20mg to Resident #2 on 06/22/21. Review of Resident #2's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for pantoprazole 40mg take 1 tablet twice daily scheduled to be administered at 8:00am and 8:00pm daily. -The entry for pantoprazole was crossed out with a note written beside the entry to clarify. -Pantoprazole was documented as administered twice daily at 8:00am and 8:00pm from 06/01/21 to 06/18/21. -There was no entry for rabeprazole 20mg take 1 tablet daily.	C 315		

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C 315	Continued From page 19 Interview with Resident #2 on 06/23/21 at 3:30pm revealed he knew his acid reflux medication was changed by his primary care provider (PCP) but did not know the name of the new medication. Interview with a former SIC at a sister facility on 06/23/21 at 12:05pm revealed: -She was responsible for clarifying medication orders for the residents in the facility. -Resident #2 was getting medications from three different pharmacies and seeing several different physicians. -She removed all medications from the resident's supply of medications that the facility did not have a current order. -Resident #2's was not administered the rabeprazole 20mg because the facility did not have a current order for the medication. -She did not know if the resident was supposed to take the pantoprazole or the rabeprazole. -She contacted Resident #2's PCP last week but he was out of town. Telephone interview with a nurse from Resident #2's primary care provider's office on 06/24/21 at 3:33pm revealed: -The pantoprazole was changed to rabeprazole. -The resident was supposed to be taking rabeprazole for his acid reflux. -The resident would have increased discomfort and heartburn if he did not receive the rabeprazole. Interview with the Administrator on 06/23/21 at 3:03pm revealed: -She had reached out to a family member to help make sure the medication orders were correct. -The former SIC did her best to keep the medication orders updated. -The former SIC was working to get the orders	C 315		

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C 315	Continued From page 20 clarified. -She did not know what medications the residents were supposed to be administered.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 2 of 3 sampled residents (Residents #1 and #2) related to a medication to treat anxiety associated with schizophrenia (Resident #1) and medications to treat benign prostatic hyperplasia (BPH) and acid reflux (Resident #2). The findings are: 1. Review of Resident #2's current FL2 dated 02/10/21 revealed diagnoses included hypotension, depression, benign prostatic hyperplasia (BPH) with urinary frequency, hypothyroidism, and shortness of breath. a.Review of Resident #2's current FL2 dated	C 330		

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C 330	Continued From page 21 02/10/21 revealed a physician's order for dutasteride (used to treat BPH) 0.5mg take 1 capsule daily. Review of Resident #2's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for dutasteride 0.5mg take 1 capsule daily scheduled to be administered at 8:00am daily. -The entry for dutasteride was crossed out with a handwritten note beside the medication name "changed to finasteride 01/22/21" with a question mark beside the date. -Dutasteride was documented as administered from 06/01/21 to 06/18/21 at 8:00am daily. Observation of Resident #2's medication on hand on 06/23/21 at 11:09am revealed there was no dutasteride 0.5mg available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 10:00am revealed: -The pharmacy had last dispensed 5 tablets of dutasteride 0.5mg to Resident #3 on 06/16/21 as an emergency fill. -Prior to 06/16/21, the last time the pharmacy had filled dutasteride 0.5mg to Resident #3 was 02/21/21 when 17 tablets were delivered to the facility. -The pharmacy did not have a current order with refills for dutasteride. Interview with Resident #2 on 06/23/21 at 3:30pm revealed: -He was having a hard time sleeping at night over the past month because he had to get up and go to the restroom so many times. -Some nights, he would have to get up 6 to 7 times to go to the restroom.	C 330		

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C 330	Continued From page 22 Interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 12:05pm revealed: -The Administrator was the medication aide for the facility. -She helped the Administrator by auditing the medication orders to make sure each resident was administered the correct medications. -Resident #2 was getting medications from three different pharmacies and seeing several different physicians. -Resident #2 was independent and drove himself to his appointments. -She did not administer any medications to the residents but did not think Resident #2 had received any medication to treat his BPH. -She removed all medications the previous week from the resident's supply of medications that the facility did not have a current order. Telephone interview with a pharmacist from the facility's contracted pharmacy on 06/24/21 at 2:36pm revealed Resident #2 was at an increased risk for urinary frequency and decreased urinary control if he was not administered the dutasteride. Telephone interview with a nurse from Resident #2's primary care provider's (PCP) office on 06/24/21 at 3:33pm revealed: -Resident #2 was prescribed dutasteride to treat his BPH. -Dutasteride was listed as an active medication for Resident #2. -The PCP was responsible for refilling Resident #2's medication for BPH. -Resident #2 was at risk for increased urinary frequency if he was not administered the dutasteride.	C 330		

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C 330	Continued From page 23 Refer to the interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 3:03pm. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 1:23pm. Refer to the telephone interview with the Nurse Consultant on 06/23/21 at 12:15pm. Refer to the interview with the Administrator on 06/23/21 at 12:40pm. b. Observation of Resident #2's medication on hand at 11:09am on 06/23/21 revealed there was a bottle containing rabeprazole (used to treat heartburn and acid reflux) 20mg take 1 tablet daily filled on 06/22/21 at Resident #2's pharmacy. Review of Resident #2's record on 06/23/21 revealed there was no physician's order for rabeprazole 20mg take 1 tablet daily. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 10:00am revealed the pharmacy did not have a medication order for rabeprazole for Resident #2. Telephone interview with a pharmacist from Resident #2's pharmacy on 06/25/21 at 11:04am revealed the pharmacy dispensed 30 tablets of rabeprazole 20mg to Resident #2 on 06/22/21. Review of Resident #2's June 2021 Medication Administration Record (MAR) revealed there was no entry for rabeprazole 20mg take 1 tablet daily.	C 330		

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C 330	Continued From page 24 Interview with Resident #2 on 06/23/21 at 3:30pm revealed his heartburn was "okay" today (06/18/21) but it was bothering him some over the past month. Interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 12:05pm revealed: -She helped the Administrator by auditing the medication orders to make sure each resident was administered the correct medications. -Resident #2 was getting medications from three different pharmacies and seeing several different physicians. -She removed all medications from the resident's supply of medications that the facility did not have a current order. -Resident #2's was not administered the rabeprazole 20mg because the facility did not have a current order for the medication. Telephone interview with a nurse from Resident #2's primary care provider's office on 06/24/21 at 3:33pm revealed: -The resident was supposed to be taking rabeprazole for his acid reflux. -The resident would have increased discomfort and heartburn if he did not receive the rabeprazole. Refer to the interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 3:03pm. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 1:23pm. Refer to the telephone interview with the Nurse Consultant on 06/23/21 at 12:15pm.	C 330		

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C 330	Continued From page 25 Refer to the interview with the Administrator on 06/23/21 at 12:40pm. Refer to the telephone interview with the Administrator on 06/25/21 at 1:26pm. 2. Review of Resident #1's current FL2 dated 04/30/21 revealed: -Diagnoses included paranoid schizophrenia, moderate intellectual disability and tobacco use. -There was an order for lorazepam 0.5mg, 1 tablet 4 times a day. Review of Resident #1's Resident Register dated 03/03/21 revealed she was admitted to the facility on 03/03/21 and discharged on 06/17/21. Review of Resident #1's record revealed: -There was an order dated 05/03/21 for lorazepam (a medication to treat anxiety) 0.5mg four times a day. -The order specified a 30-day supply with no refills. -There was a piece of paper documenting 5 lorazepam tablets were sent with Resident #1 when she was discharged to another facility on 06/17/21. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 11:11am revealed: -The pharmacy received a faxed copy of Resident #1's FL2 dated 03/03/21. -On the FL2 there was an order for lorazepam 0.5mg, four times a day. -They dispensed 12 tablets as an emergency dose because they needed a prescription from the primary care provider (PCP). -The facility was responsible for providing the	C 330		

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hard copy of the prescription, which they requested, but the pharmacy never received one from either the facility or the PCP.
-The pharmacy received an electronic prescription from the PCP on 05/03/21 for lorazepam 0.5mg four times a day.
-The pharmacy dispensed a 30-day supply (120 tablets) of lorazepam 0.5mg on 05/03/21 and it was delivered to the facility on 05/04/21.
-The 30-day supply of lorazepam should have lasted through 06/02/21.
-The pharmacy contacted the PCP on 06/09/21 for a refill but the PCP denied the refill request, stating Resident #1 needed to be seen by the PCP before she would authorize a refill.

Review of Resident #1's May 2021 Medication Administration Record (MAR) revealed:
-There was an entry for lorazepam 0.5mg, 1 tablet 4 times a day.
-The lorazepam was documented as administered four times a day from 05/04/21 to 05/31/21.

Review of Resident #1's June 2021 MAR revealed:
-There was an entry for lorazepam 0.5mg, 1 tablet 4 times a day.
-The lorazepam was documented as administered four times a day from 06/01/21 to 06/16/21.
-The lorazepam was documented as administered twice on 06/17/21.

Interview with the Administrator on 06/23/21 at 12:10pm and 2:48pm revealed:
-She was the medication aide for the facility.
-Resident #1 "always" had lorazepam available and she administered it 4 times a day until she was discharged on 06/17/21.

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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 330	Continued From page 27 -All medications were delivered from the facility's contracted pharmacy, usually a 90-day supply. -She did not use a back up pharmacy to get any medications for Resident #1. -All medications were sent with Resident #1 when she was discharged, and they were listed on a piece of paper that was given to the guardian's supervisor. -She did not remember how many lorazepam were sent with Resident #1. -The facility requested the guardian obtain a psychology referral because Resident #1's behaviors of inappropriately using the bathroom in her room, smoking in her room which was against policy, extinguishing cigarettes in flammable items and refusing to come out of her room continued even with 4 doses of lorazepam daily. Telephone interview with a nurse at Resident #1's PCP's office on 06/24/21 at 1:37pm revealed: -Resident #1 was prescribed lorazepam for anxiety related to her schizophrenia diagnosis. -A prescription for lorazepam was written for 30 days and required a follow-up with the PCP for all refills. -Lorazepam was a medication that needed to be tapered. -If Resident #1 did not receive lorazepam as ordered she could have symptoms such as worsening schizophrenic episodes, agitation, trouble sleeping, rebound anxiety, headaches, seizures or irritability. -Resident #1 did not have any pending appointments to be seen by the PCP. Telephone interview with the Administrator on 06/25/21 at 1:26pm revealed she did not understand what happened with Resident #1's lorazepam; she always had lorazepam available	C 330		

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C 330	Continued From page 28 to administer. Refer to the interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 3:03pm. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 1:23pm. Refer to the telephone interview with the Nurse Consultant on 06/23/21 at 12:15pm. Refer to the interview with the Administrator on 06/23/21 at 12:40pm. Refer to the telephone interview with the Administrator on 06/25/21 at 1:26pm. _____ Interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 3:03pm revealed: -She completed medication audits weekly for the Administrator. -The last medication audit was completed the previous week. -She compared the MAR to the medications available to administer and the MAR to the medication orders in each resident's record. -She had worked with the Administrator for a month or two to make sure all medication orders were accurate. -She knew some of the medications on the MAR did not match the medications available in the facility for administration for some residents. -She was responsible for faxing orders to the pharmacy and updating the MAR when a new medication order was received for a resident. -She was responsible for calling a resident's physician for new refills. -She tried to contact each resident's primary care	C 330		

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C 330	Continued From page 29 provider (PCP) for new refills. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 1:23pm revealed: -The facility was responsible for faxing medication orders to the pharmacy unless the physician sent the order directly to the pharmacy. -The pharmacy was responsible for faxing a resident's physician for refills. -The pharmacy would notify the facility to contact a resident's physician for refills if they had not received a response and it was almost time to refill the medication to be sent in the cycle fill. Telephone interview with the Nurse Consultant on 06/23/21 at 12:15pm revealed: -She was responsible for completing the facility's quarterly medication reviews. -The facility had contacted her to come to the facility to help with the medications about 7 to 10 days ago. -She visited the facility on 06/21/21 and completed a medication review for each resident. -The facility was responsible for following up on her recommendations with each resident's physician ensuring each resident was administered the correct medications. Interview with the Administrator on 06/23/21 at 12:40pm revealed: -She was the medication aide for the facility. -She did not know what medications she had administered to the residents. -She did not know if each resident was getting the correct medications or not. Telephone interview with the Administrator on 06/25/21 at 1:26pm revealed she was responsible for administering all medications.	C 330		

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C 330	Continued From page 30 The facility failed to administer medications as ordered including Resident #1's lorazepam to treat anxiety associated with her schizophrenia, increasing her risk of experiencing increased schizophrenic episodes and trouble sleeping; failed to administer dutasteride to treat benign prostatic hyperplasia (BPH) (Resident #2) resulting in Resident #2 getting up multiple times each night to urinate and failed to administer rabeprazole as ordered to treat acid reflux (Resident #2) increasing his risk of experiencing heartburn and discomfort. These failures were detrimental to the health and welfare of the residents and constitutes a Type B Violation. The facility failed to provide a plan of protection in accordance with G.S. 131D-34 by 06/25/21.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record reviews interviews the facility failed to ensure the the staff who administered a	C 341		

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medication was the same staff who documented the administration on the Medication Administration Record.

The findings are:

Review of a resident's June 2021 Medication Administration Record (MAR) revealed:
-The Administrator's signature at the bottom of the MAR looked different from the Administrator's signature on other documents at the facility.
-The Administrator's initials documenting administration of medications looked different from the Administrator's initials on other documents at the facility.

Interview with the Administrator on 06/23/21 at 11:54am revealed:
-She was the only one who ever documented administration of medications on resident's MARs.
-She did not know why her initials looked different on different documents in the facility.

Interview with a former supervisor-in-charge (SIC) at a sister facility on 06/23/21 at 11:54am revealed:
-She never touched the MAR.
-The Administrator was the only person at the facility to document on the MAR.

Interview with a SIC at a sister facility on 06/25/21 at 1:26pm revealed:
-The Administrator relied on a former SIC to help her with medication administration.
-The former SIC put resident medications in a cup and the Administrator administered the medications to the residents.
-The former SIC documented administration on the MAR by signing the Administrators initials.

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C 341	Continued From page 32 -If the former SIC said she was not signing the MAR, "she was not being truthful". -She was able to tell the difference in how the Administrator signed and how the former SIC signed for the Administrator. -The former SIC had no authority to sign for the Administrator. -She remembered it most recently being done on the evening of 06/21/21 and 06/22/21. Interview with the Administrator on 06/25/21 at 1:26pm revealed: -She did not deny anything the family member told the surveyor. -The former SIC documenting on the MAR never administered any medications to the residents.	C 341		
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	C 342		

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signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure the Medication Administration Record (MAR) was accurate for 2 of 3 sampled residents (Residents #1 and #2) related to a medication to treat anxiety (#1) and medications to treat benign prostatic hyperplasia (BPH) and acid reflux (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 04/30/21 revealed:
-Diagnoses included paranoid schizophrenia, moderate intellectual disability and tobacco use.
-There was an order for lorazepam 0.5mg, 1 tablet 4 times a day.

Review of Resident #1's Resident Register dated 03/03/21 revealed she was admitted to the facility on 03/03/21.

Review of Resident #1's record revealed:
-There was an order dated 05/03/21 for lorazepam (a medication to treat anxiety) 0.5mg four times a day.
-The order specified a 30-day supply with no refills.
-There was a paper documenting 5 lorazepam tablets were sent with Resident #1 when she was discharged on 06/17/21.
-There was no documentation Resident #1 brought any lorazepam from her previous facility when she was admitted on 03/03/21.

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C 342	Continued From page 34 Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 11:11am revealed: -The pharmacy received an electronic prescription from the Primary Care Provider (PCP) on 05/03/21 for lorazepam 0.5mg four times a day and specified no refills. -The pharmacy dispensed a 30-day supply (120 tablets) of lorazepam 0.5mg on 05/03/21 and it was delivered to the facility on 05/04/21. -The 30-day supply of lorazepam should have lasted through 06/02/21. -The pharmacy contacted the PCP on 06/09/21 for a refill but the PCP denied the refill request, stating Resident #1 needed to be seen by the PCP before she would authorize a refill. Review of Resident #1's May 2021 Medication Administration Record (MAR) revealed: -There was an entry for lorazepam 0.5mg, 1 tablet 4 times a day. -The lorazepam was documented as administered four times a day from 05/04/21 to 05/31/21. Review of Resident #1's June 2021 MAR revealed: -There was an entry for lorazepam 0.5mg, 1 tablet 4 times a day. -The lorazepam was documented as administered four times a day from 06/01/21 to 06/16/21. -The lorazepam was documented as administered twice on 06/17/21. Interview with the Administrator on 06/23/21 at 11:54am and 12:10pm revealed: -All of Resident #1's lorazepam was delivered from the facility's contracted pharmacy. -She always had lorazepam available to	C 342		

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C 342	Continued From page 35 administer. -She did not know the lorazepam order written on 05/03/21 was written for a 30-day supply and did not have a refill; she thought it was delivered three months at a time. -She did not know a refill request had been denied. -She did not know why she still had 5 tablets on 06/17/21 if her 30-day supply would have run out on 06/02/21. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 1:23pm. Refer to the interview with a former supervisor-in-charge (SIC) at a sister facility on 06/23/21 at 12:05pm. Refer to the interview with the Administrator on 06/23/21 at 12:40pm. 2. Review of Resident #2's current FL2 dated 02/10/21 revealed diagnoses included hypotension, depression, benign prostatic hyperplasia (BPH) with urinary frequency, hypothyroidism, and shortness of breath. a. Review of Resident #2's current FL2 dated 02/10/21 revealed a physician's order for dutasteride (used to treat BPH) 0.5mg take 1 capsule daily. Review of Resident #2's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for dutasteride 0.5mg take 1 capsule daily scheduled to be administered at 8:00am daily. -The entry for dutasteride was crossed out with a note written beside the medication name	C 342		

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"changed to finasteride 01/22/21" with a question mark beside the date.
-Dutasteride was documented as administered from 06/01/21 to 06/18/21 at 8:00am daily.

Observation of Resident #2's medication on hand on 06/23/21 at 11:09am revealed there was no dutasteride 0.5mg available to be administered.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 10:00am revealed:
-The pharmacy had dispensed 5 tablets of dutasteride 0.5mg to Resident #2 on 06/16/21 as an emergency fill.
-Prior to 06/16/21, the last time the pharmacy filled dutasteride 0.5mg to Resident #2 was 02/21/21 when 17 tablets were delivered to the facility.
-The pharmacy did not have a current order with refills for dutasteride.
-The pharmacy had a note to not fill medications for Resident #2 unless it was for an emergency refill.

Interview with a former supervisor-in-charge (SIC) at a sister facility on 06/23/21 at 12:05pm revealed she did not administer any medications to the residents but did not think Resident #2 had received any medication to treat his BPH.

Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 1:23pm.

Refer to the interview with as former SIC at a sister facility on 06/23/21 at 12:05pm.

Refer to the interview with the Administrator on 06/23/21 at 12:40pm.

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C 342	Continued From page 37 b. Review of Resident #2's current FL2 revealed a physician's order for pantoprazole (used to treat heart burn) 40mg take 1 tablet twice daily. Review of Resident #2's June 2021 Medication Administration Record (MAR) revealed: -There was an entry for pantoprazole 40mg take 1 tablet twice daily scheduled to be administered at 8:00am and 8:00pm daily. -The entry for pantoprazole was crossed out with a note written beside the entry to clarify. -Pantoprazole was documented as administered twice daily at 8:00am and 8:00pm from 06/01/21 to 06/18/21. Observation of Resident #2's medication on hand at 11:09am on 06/23/21 revealed there was no pantoprazole available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 10:00am revealed: -The pharmacy dispensed 34 tablets of pantoprazole 40mg to Resident #2 on 02/25/21. -The pharmacy had not received an order to discontinue the pantoprazole. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/23/21 at 1:23pm. Refer to the interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 12:05pm. Refer to the interview with the Administrator on 06/23/21 at 12:40pm. _____ Telephone interview with a pharmacy technician	C 342		

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C 342	Continued From page 38 from the facility's contracted pharmacy on 06/23/21 at 1:23pm revealed: -The pharmacy printed a paper Medication Administration Record (MAR) for all the residents in the facility monthly and delivered them to the facility. -The MARs were printed on a triplicate form. -The facility was responsible for making corrections on the MAR and sending a copy back to the pharmacy monthly for the pharmacy to make corrections to the MAR. -The facility never sent the form to make the MAR corrections back to the pharmacy. Interview with a former supervisor-in-charge at a sister facility on 06/23/21 at 12:05pm revealed: -She helped the Administrator make sure the MARs were correct for each resident by auditing the MARs weekly. -She was responsible for making corrections to the MAR when a resident had a new medication order. -Sometimes the pharmacy would send an updated copy of the MAR to the facility after a medication change. -She did not know why the Administrator was signing off that she had administered medications that were not available in the facility. Interview with the Administrator on 06/23/21 at 12:40pm revealed: -She was responsible for documenting on the MAR when she administered a medication to a resident. -She did not know why she had documented she had administered medications to the residents that she did not have available to administer. -She knew she was suppose to sign on the MAR she administered medications but she did not know what she was administering.	C 342		

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C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to maintain accurate records of receipt and administration of a controlled substance on a Controlled Substance Count Sheet (CSCS) for 1 of 1 sampled resident (Resident #1) related to a medication to treat anxiety. The findings are: Review of Resident #1's current FL2 dated 04/30/21 revealed: -Diagnoses included paranoid schizophrenia, moderate intellectual disability and tobacco use. -There was an order for lorazepam 0.5mg, 1 tablet 4 times a day. Review of Resident #1's Resident Register dated 03/03/21 revealed she was admitted to the facility on 03/03/21 and discharged to another facility on 06/17/21. Review of Resident #1's record revealed: -There was an order dated 05/03/21 for lorazepam (a medication to treat anxiety) 0.5mg four times a day. -The order specified a 30-day supply with no	C 367		

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FAIRVIEW FAMILY CARE HOME # 1	256 GRAVELY BRANCH ROAD FLETCHER, NC 28732

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C 367	Continued From page 40	C 367		

refills.
-There was a piece of paper documenting 5 lorazepam tablets were sent with Resident #1 when she was discharged from the facility on 06/17/21.

Review of Resident #1's June 2021 Medication Administration Record (MAR) revealed:
-There was an entry for lorazepam 0.5mg, 1 tablet 4 times a day.
-Lorazepam was documented as administered four times a day from 06/01/21 to 06/16/21.
-Lorazepam was documented as administered twice on 06/17/21.

Review of Resident #1's controlled substance count sheet (CSCS) revealed:
-There was a CSCS for lorazepam 0.5mg, 1 tablet 4 times a day that was started on 05/29/21.
-The CSCS documented 60 of the 120 lorazepam that were dispensed in 2 bubble packs.
-Lorazepam was documented as administered 4 times a day from 05/29/21 through 06/04/21.
-Lorazepam was documented as administered 8 times on 06/05/21.
-Lorazepam was documented as administered 4 times on 06/06/21.
-Lorazepam was documented as administered 2 times on 06/07/21.
-Lorazepam was documented as administered 4 times a day from 06/08/21 through 06/16/21.
-Lorazepam was documented as administered 2 times on 06/17/21.
-The declining balance column was left blank on the entire CSCS.
-The CSCS documented 80 doses administered.
-There was a column of declining numbers written in by the date that started at 45 and ended at 8 and appeared to document the declining balance.

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C 367	Continued From page 41 -The declining balance of 43 tablets documented on 05/30/21 was a repeat of the count documented on 05/29/21. -The declining balance of 28 tablets documented on 06/03/21 was a repeat of the count documented on 06/02/21. -The declining balance stopped on 06/07/21 with a balance of 8. Telephone interview with a representative from the facility's contract pharmacy on 06/23/21 at 11:11am revealed: -The pharmacy received a faxed copy of Resident #1's FL2 dated 03/03/21. -The FL2 documented an order for lorazepam 0.5mg, four times a day. -They dispensed 12 tablets, a 3-day supply, of 0.5mg lorazepam on 03/03/21 as an emergency dose because they needed a prescription from the primary care provider (PCP). -The pharmacy received an e-prescription from the PCP on 05/03/21 for lorazepam 0.5mg four times a day. -The pharmacy dispensed a 30-day supply (120 tablets in 2 bubble packs) of lorazepam 0.5mg on 05/03/21 and it was delivered to the facility on 05/04/21. -The pharmacy dispensed a total of 132 tablets of lorazepam 0.5mg between 03/03/21 and 05/03/21. -The 30-day supply of lorazepam dispensed on 05/03/21 should have lasted through 06/02/21. Interview with the Administrator on 06/23/21 at 10:45am and 11:54am revealed -She was told on 05/28/21 that she needed to complete a CSCS for lorazepam so she started one on 05/29/21. -She was the only person who documented on the CSCS.	C 367		

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C 367	Continued From page 42 -She had never been trained on how to complete a CSCS. -She did not know why 06/05/21 was entered 2 times, indicating 8 doses were administered. -She did not give a "double dose" on 06/05/21. -Resident #1 always received the lorazepam 4 times a day. -She did not know why 2 doses were documented as administered on 06/07/21 when it was ordered 4 times a day and the MAR documented 4 times a day administration. -She thought the number down the side by the date was the number of tablets remaining and did not know why it was inaccurate. -She did not know how on 05/29/21 there could be 45 tablets available, rather than 20, because 120 were delivered on 05/04/21 and Resident #1 had not missed any doses for the previous 25 days. -She did not understand why the CSCS documented 80 administrations if there were only 45 doses initially and no additional medications had been delivered from the pharmacy. -She was the only one who ever signed the CSCS so she did not know why her initials looked different on 05/31/21. -She did not know why there were incorrect initials documented on 06/07/21 and 06/08/21. Interview with the Administrator on 06/23/21 at 12:10pm and 2:48pm revealed: -Resident #1 was never out of lorazepam and she administered it 4 times a day. -All medications were sent with Resident #1 when she was discharged on 06/17/21, and they were written on a piece of paper that was given to the guardian's supervisor. -She did not remember how many lorazepam were sent with Resident #1 at discharge.	C 367		

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C 612	Continued From page 43	C 612		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations and interviews, 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 during the global Coronavirus (COVID-19) pandemic as related to COVID-19 screening of staff, visitors and residents. The findings are:	C 612		

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C 612	Continued From page 44 Review of the current CDC guideline for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 03/29/21 revealed: -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. Review of the NCDHHS guidelines for the prevention and spread of the Coronavirus Disease in LTC facilities dated 05/05/21 revealed: -Recommended routine infection prevention control (IPC) practices during the COVID-19 pandemic included screening anyone entering a healthcare facility for signs and symptoms of COVID-19. -Establishing a process to ensure visitors entering the facility are assessed for symptoms of COVID-19. Review of the facility's infection control policy revealed the policy had not been updated since the beginning of the COVID-19 pandemic. Observation on 06/23/21 at 9:00am revealed two surveyors entered the facility with no COVID-19 screening or temperatures checks and there were no screening questionnaire or thermometer located near the entrance to the facility. Observation of the living room on 06/23/21 at 9:00am revealed: -There was a holder on the wall by the front door for an infra-red thermometer but the thermometer was not in the holder. -There was a hand-held thermometer	C 612		

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C 612	Continued From page 45 approximately 24 feet away from the front door on the dining room table, but the Administrator did not offer to screen the surveyor. Interview with a resident on 06/18/21 at 11:48am revealed: -Staff did not screen her for COVID-19 symptoms or take her temperature. -There was a thermometer available if residents wanted to check their own temperatures. Interview with a second resident on 06/23/21 at 9:16am revealed: -He received his COVID-19 vaccine about a month ago. -Screening questions were never asked since the beginning of the pandemic, just temperature checks. -Temperature checks were stopped about the time the COVID-19 vaccines were given. Interview with a third resident on 06/23/21 at 9:30am revealed she did not remember the Administrator screening any visitors that had entered the facility in the last several weeks. Interview with the Administrator on 06/23/21 at 9:20am revealed: -She screened visitors to the facility sometimes but not everyone. -She tried to screen visitors at least once a week. -She did not understand why she needed to screen visitors to the facility. -A surveyor asked the Administrator if she wanted to check her temperature and the Administrator said "no."	C 612		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights	C 912		

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C 912	Continued From page 46 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 review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care, personal care and supervision, and medication administration. The findings are: 1. Based on observations, interviews and record reviews the facility failed to provide supervision to 1 of 3 sampled residents (Resident #1) who needed supervision while smoking. [Refer to Tag 0243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type Unabated B Violation)]. 2. Based on interviews and record reviews the facility failed to ensure a referral to meet acute healthcare needs was made for 1 of 3 sampled residents (Resident #1) related to a psychology referral. [Refer to Tag 246, 10A NCAC 13G .0902(b) Health Care (Type Unabated A1 Violation)]. 3. Based on observations, interviews and record reviews the facility failed to administer medications as ordered for 2 of 3 sampled residents (Residents #1 and #2) related to a medication to treat anxiety associated with schizophrenia (Resident #1) and medications to treat benign prostatic hyperplasia (BPH) and acid	C 912		

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C 912	Continued From page 47 reflux (Resident #2). [Refer to Tag 0330, 10A NCAC 13G .1004(a) Medication Administration (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: Based on observations, record reviews and interviews the facility failed to ensure each resident was free of neglect related to management and other staff. The findings are: 1. Based on observations, record reviews and interviews the Administrator failed to ensure the management and total operations of the facility were maintained to ensure compliance with the rules and statutes of adult care homes to protect each resident's rights to receive adequate and appropriate care and services and to be free of neglect as related to resident supervision, healthcare referral, medication administration, maintaining a controlled substance count sheet and infection prevention. [Refer to Tag 0185, 10A NCAC 13G .0601(a) Management and other staff (Type A1 Violation)].	C 914		