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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING		R	
		FCL011022	B. WING		06/25/2021	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	,		
FAIRVIEW	FAMILY CARE HOME #	1	AVELY BRANCH RO ER, NC 28732	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLET THE APPROPRIATE DATE	ГЕ
C 000	Initial Comments		C 000			
	follow-up survey initia					
C 185	10A NCAC 13G .060 ⁻¹ Staff	1(a) Management and Other	C 185			
	Staff (a) A family care hon responsible for the to home and shall also be Division of Health Secounty department of and maintaining the range of the co-administrator, share equal responsible for the operation of the	rvice Regulation and the social services for meeting ules of this Subchapter. when there is one, shall bility with the administrator le home and for meeting ules of this Subchapter. or also refers to				
	interviews the Admini management and tota were maintained to en rules and statutes of each resident's rights	ns, record reviews and strator failed to ensure the all operations of the facility ensure compliance with the adult care homes to protect to receive adequate and services and to be free of				

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED
		FCL011022	B. WING		06	R / 25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	,	
		256 GRA	VELY BRANCH RO			
FAIRVIEW	/ FAMILY CARE HOME #	1 FLETCHE	ER, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 185	Continued From page	e 1	C 185			
	healthcare referral, m	edication administration, ed substance count sheet				
	The findings are:					
	12:40pm revealed: -She did not know wh administered to the re	each resident was getting the				
	06/25/21 at 1:26pm re- The Administrator waday-to-day operations The Administrator action the facility and was and ensuring the accomedication administration administration and the substance count sheet trained. A family member water was sages from the pubecause she did not lead a family member mater appointment dates are she relied on a form for help with the oper for a long time".	(SIC) at a sister facility on evealed: as responsible for the sof the facility. Iministered all medications aresponsible for maintaining tracy of the facility's ation records. able completing controlled ets as she had never been so responsible for taking thone answering machine know how to do it. de arrangements for some and informed her of the and times. er SIC from a sister facility ation of the facility and "had				
	rule areas:	identified in the following				
		ions, interviews and record led to provide supervision to				

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Division of Health Service Regulation

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		R	
		FCL011022	B. WING		06/25/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	1	LY BRANCH F	ROAD		
040.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	, NC 28732	PROVIDER'S PLAN OF CORRECTION	d 0.50	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 185	Continued From page	2	C 185			
	needed supervision w 0243, 10A NCAC 130	ents (Resident #1) who while smoking. [Refer to Tag G .0901(b) Personal Care abated Type B Violation)].				
	facility failed to ensure were met for 1 of 3 sa #1) related to a psych	• ,				
	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)].					
	reviews the facility fai medications as order residents (Residents medication to treat ar schizophrenia (Residente treat benign prostation reflux (Resident #2).	ed for 2 of 3 sampled #1 and #2) related to a				
	failed to ensure the the medication was the se the administration on Administration Record	eviews interviews the facility ne staff who administered a ame staff who documented the Medication d. [Refer to Tag 0341, 10A Medication Administration				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3 AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		FCL011022	B. WING		06	R 5/ 25/2021
NAME OF PRO	/IDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	·	
		. 256 GRA	VELY BRANCH RO	DAD		
FAIRVIEW FA	AMILY CARE HOME #	1 FLETCH	ER, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
6. re A of re m (E 10 A 7. fare su S (Fair 1 D 8. fare gu (C H in (C su Ta P Til m co fare w	eviews the facility farministration Record of 3 sampled resident of 3 sampled resident elated to a medication dedications to treat I BPH) and acid reflux 0A NCAC 13G .100 dministration (Stand Deceipt and administration (Stand Deceipt and administration administration and the ceipt and administration (SCSS) for 1 of Resident #1) related existing (Refer to Tarunous (Resident #1) related existing (Refer to Tarunous (Ref	tions, interviews and record iled to ensure the Medication of (MAR) was accurate for 2 ts (Residents #1 and #2) on to treat anxiety (#1) and benign prostatic hyperplasia of (#2). [Refer to Tag 0342, 4(j) Medication dard Deficiency)]. It was and record reviews the sain accurate records of reation of a controlled rolled Substance Count of 1 sampled resident to a medication to treat g 0367, 10A NCAC 13G Substances (Standard tions and interviews, the re recommendations and ters for Disease Control Carolina Department of ervices (NCDHHS) were the global Coronavirus in as related to COVID-19 sitors and residents. [Refer to C 13G .1701(c) Infection in Deficiency)].	C 185			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R	
		FCL011022	B. WING			
		FCL011022	J		06/25/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		256 GRA	VELY BRANCH I	ROAD		
FAIRVIEW	FAMILY CARE HOME #	1	ER, NC 28732			
			<u> </u>			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
				DEFICIENCY)		
0.405	0 " 15		0.405			
C 185	Continued From page	e 4	C 185			
	in flammable items; fa	ailed to obtain a healthcare				
	referral for a resident					
		ical behaviors, failed to				
		lers related to prostate and				
	reflux medications, fa					
		ed related to an anxiety,				
		nedication 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					
		ted to infection prevention				
	~	emic. The Administrator's				
		adequate and inappropriate				
	care of residents and					
	constitutes a Type A1					
	constitutes a Type A	Violation.				
	The facility failed to n	rovide a plan of protection in				
		. 131D-34 by 06/25/21.				
	accordance with 0.0.	. 131D-34 by 00/23/21.				
0.040						
C 243		1(b) Personal Care and	C 243			
	Supervision					
	101 11010 100 555	4.5				
	10A NCAC 13G .090	1 Personal Care And				
	Supervision					
		e supervision of residents in				
		n resident's assessed needs,				
	care plan and current	symptoms.				
	TI: 5					
	This Rule is not met	•				
	FOLLOW-UP TO A T	ALE R AIOPATION				
	Deced on the confirm	and the manifelia Torre D				
		ngs, the previous Type B				
	Violation was not aba	itea.				
	December 1 "					
		ns, interviews and record				
		iled to provide supervision to				
		ents (Resident #1) who				
	needed supervision w	vhile smoking.				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
AND FLAIN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPL	EIED
		FCL011022	B. WING			⋜ 25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE	•	
NAME OF T	NOVIDEN ON 301 1 EIEN		/ELY BRANCH I			
FAIRVIEW	FAMILY CARE HOME #	1	R, NC 28732	NOAD		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORR	ECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 243	Continued From page	e 5	C 243			
	The findings are:					
		d's current FL2 dated agnoses included paranoid rate intellectual disability and				
	03/03/21 revealed: -She was admitted to -A notice of discharge administrator on 06/1 was caught smoking	5/21 because Resident #1 in her bedroom multiple follow the facility's smoking				
	Review of Resident # assessment for smok	1's record revealed no ing safety.				
	03/03/21 revealed: -The residents may o -If a resident fails to a smoking policy, the fa confiscate all smoking -For the first offense, with the facility staff fo with supervisionFor the second offen place for a six- month -The third violation of resident having all sm confiscated for the du and a 30-day notice v	Resident #1's guardian on nly smoke outdoors.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	E SURVEY PLETED	
		FCL011022	B. WING		06	R 5/ 25/2021
NAME OF D	ROVIDER OR SUPPLIER		DRESS, CITY, STAT		1 00	#E0/E0E 1
NAIVIE OF P	ROVIDER OR SUPPLIER					
FAIRVIEW	FAMILY CARE HOME #	1	ELY BRANCH R R, NC 28732	ROAD		
	CUMMADVCT		·	DDOMDEDIC DI ANI OF C	ODDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 243	Continued From page	e 6	C 243			
	_	ithin the facility occurs; this f state law and is a danger to				
	10:00am revealed: -Resident #1 smoked	_				
	burn holes that conta	revealed: odor. set had multiple cigarette				
	9:55am revealed: -Resident #1 was disconformed states to be supervised when she had a history of sher previous facilityResident #1 set off thago at 1:30am when roomOn 06/15/21 she too Resident #1 and wher room was smoky and down in her closet" wextinguished cigarette.	aff Resident #1 would need in she was smoking because smoking in her bedroom at the smoke alarm two weeks she was smoking in her in the work was smoking in her in the work a breakfast tray to in she entered the room, the in the work was "hunkered with a lighter and an				

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the bedroom but Resident #1 denied smoking.

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	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		FCL011022	B. WING		06/25/2021
NAME OF D	ROVIDER OR SUPPLIER	ethert and	RESS, CITY, STA	TE ZID CODE	, , , , , , , , , , , , , , , , , , , ,
NAME OF P	ROVIDER OR SUPPLIER		ELY BRANCH F		
FAIRVIEW	FAMILY CARE HOME #	1	. NC 28732	ROAD	
			1, 140 20732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 243	Continued From page	e 7	C 243		
	-Resident #1 was instan area designated for always stay outside we residents were outside. She did not collect the Resident #1 when shoutsideShe cleaned Resider week and "usually" for wicker basket on her confront Resident #1 because "I never fusside no good"Because Resident #1 access to cigarettes in monitoredShe did not know who Resident #1 from smooth.	tructed to smoke outside in or smoking but she did not with her because other e and could monitor her. he cigarette butts from e was finished smoking Int #1's bedroom once a hund 1-3 cigarette butts in a dresser. She did not about the cigarette butts at people because it would 1 should not have had inside, she was not hat else to do to prevent			
	sister facilities on 06/ -A few weeks ago, on resident from a sister for Resident #1 throuResident #1 had a lit the SIC went inside to allowed to smoke insiResident #1 was known and ask anyone she of property to light her current to l	cigarette in her hand when be tell her she was not lide. Sown to lean out her window could see on the facility's igarettes. Tree other residents who facilities who gave Resident ghter, even though they			

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in her room, but nothing stopped her from

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	IED
					R	
		FCL011022	B. WING		06/2	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
EAID\/IE\A	FAMILY CARE HOME #	256 GRAVI	ELY BRANCH I	ROAD		
FAIRVIEW	FAMILY CARE HOME #	FLETCHER	R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETE DATE
				DEFICIENCY)		
C 243	Continued From page	e 8	C 243			
	continuing to do it.					
		vare of the smoking rules				
	because she signed t					
	•	ent #1 was admitted to the				
	facility.	on ,, i was admined to the				
	•	esident #1 was given three				
		three written warnings and				
	then received a notice					
	smoking in her room.					
	-They attempted to co	ontact the guardian when the				
	warnings were given.					
		rom a sister facility on				
	06/18/21 at 11:16 rev					
		r yesterday that Resident #1 I because she started a fire				
		she really meant was				
		ing out her lit cigarettes in				
		closet floor, incontinence				
	briefs and windowsill;					
	flammable.					
	-There was not a "full	fire"- just smoldering and				
	melting incontinence					
	-Other than continuing	g to tell her to not smoke in				
	her room, no other me	easures were put in place to				
	stop her behaviors.					
	Review of Resident #	1's record revealed:				
		dwritten notes dated and				
		1, the Administrator and a				
	SIC from a sister facil					
		2/21 documented Resident				
		I warning due to smoking in				
	her room.	-				
	-The note dated 05/1	1/21 documented Resident				
		nd verbal warning due to				
	smoking in her room.					
		4/21 documented Resident				
	#1 was given a third \					
	smoking in her room	and this note also served as				

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	of Health Service Regu		0/0) 1/11/17/17/17	CONCERNATION	Love Batte GUBVEV
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,		152.111.16/11.1611.1161.152.11	A. BUILDING: _		00 22.25
			B. WING		R
		FCL011022	B. WING		06/25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
EVID//IE/V	FAMILY CARE HOME #	256 GRA	VELY BRANCH F	ROAD	
FAIRVIEW	FAMILI CARE HOME #	' FLETCHI	ER, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 243	Continued From page	9	C 243		
	contact the guardian of the note dated 05/21 #1 was given a written her room, documenting was caught smoking in immediately discharge contact the guardian of the note dated 06/18 guardian was given a due to Resident #1 smoked to Resident Resi	7/21 documented Resident in warning about smoking in ing that the next time she in her room she would be ed; they attempted to without success . 5/21 documented the 48-hour notice of discharge moking in her room. with a representative from anship agency on 06/24/21 In Resident #1's guardian ause she was deemed rmed of the notice of 1 by the facility's e was told Resident #1 red out of the facility by ause Resident #1 was e the building multiple times both verbal and written upervise Resident #1, who of smoking in her bedroom, #1 continuing to smoke in ish cigarettes in flammable o smoke and smolder and isk of having a fire. This all to the safety of all he facility and constitutes a			
	The facility provided a accordance with G.S.	 a plan of protection in 131D-34 on 06/18/21.			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		FCL011022	B. WING		00	R 6/ 25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
EAID\(IE\A	FAMILY CARE HOME #		VELY BRANCH RO	AD		
FAIRVIEW	FAMILY CARE HOME #	1 FLETCH	ER, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 246	Continued From page	e 10	C 246			
C 246	10A NCAC 13G .090	2(b) Health Care	C 246			
	` '	2 Health Care assure referral and follow-up nd acute health care needs				
	This Rule is not met FOLLOW-UP TO A T					
	Based on these findir Violation was not aba	ngs, the previous Type A1 ted.				
	facility failed to ensur were met for 1 of 3 sa	and record reviews the e acute healthcare needs ampled residents (Resident nology referral for a resident symptoms.				
	The findings are:					
	04/30/21 revealed dia	1's current FL2 dated agnoses included paranoid rate intellectual disability and				
		1's Resident Register dated e was admitted to the facility				
	Review of Resident # was no assessment f	1's record revealed there or smoking safety.				
	#1's Primary Care Ph at 1:37pm revealed: -Resident #1 was see -At that appointment	with a nurse from Resident ysician (PCP) on 06/25/21 en by the PCP on 04/30/21. a psychology referral was PCP thought Resident #1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUM PINO COMPLETED						
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLE	ובט
					R	
		FCL011022	B. WING		06/25	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE		
EAID\/IE\A	ZEAMILY CARE HOME #	256 GRAV	ELY BRANCH I	ROAD		
FAIRVIEW	FAMILY CARE HOME #	FLETCHE	R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 246	Continued From page	e 11	C 246			
C 240	had psychological iss addressed by the PC -The psychology providines, leaving messal machine for a return of the psychology provided return calls from the food to the psychology provided return calls from the food to the psychology provided return calls from the food the psychology provided return calls from the food the psychology provided return calls from the food the psychology provided return the psychology psychology provided return the psychology psychol	ues that could not be P. rider called the facility three ges on the answering call. rider never received any facility, so they sent a notice is PCP on 05/28/21 stating make contact. For Protection received on 103/21 survey written for a resident #1 revealed: ntact guardian to meet at ER	C 240			
	signed by Resident # SIC from a sister facil -The note dated 05/0; #1 was given a verba her roomThe note dated 05/1; #1 was given a secon smoking in her roomThe note dated 05/1; #1 was given a third was moking in her room, her 1st written warning contact the guardian of the note dated 05/2; #1 was given a writte her room, documenting	dwritten notes dated and 1, the Administrator and a lity. 2/21 documented Resident I warning due to smoking in 1/21 documented Resident ad verbal warning due to 4/21 documented Resident verbal warning due to and this note also served as ag and they attempted to without success. 7/21 documented Resident in warning about smoking in ag that the next time she in her room she would be				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL011022	B. WING		R 06/25	5/2021
	ROVIDER OR SUPPLIER / FAMILY CARE HOME #	STREET ADI	DRESS, CITY, STA ELY BRANCH I R, NC 28732		1 00/20	72021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 246	contact the guardian -The note dated 06/1 guardian was given a due to Resident #1 si Observation of Resid 06/18/21 at 10:13am -The bedroom had a -The carpet in the clo cigarette burns and o ashFeces was smeared the closetThe windowsill conta burn marks. Interview with the Adr 3:24pm revealed: -Resident #1's guardi for Resident #1 to be before she was admit -She asked the guard referral but the guard -She thought she cour referral without the guard -She thought of a new have an FL2 signed a medicationsThe guardian did not visit as requested by -She did not request because she thought one who could reque	without success . 5/21 documented the 48-hour notice of discharge moking in her room. ent #1's bedroom on revealed: foul odor. set had several holes from ne hole contained cigarette on two of the three walls in sined more than 50 cigarette ministrator on 06/18/21 at an was supposed to arrange evaluated by psychology sted. lian to obtain a psychology ian never followed-up. Ild not obtain a psychology uardian's permission. Ident #1 set off the fire alarm he was smoking in her oted the entire home. In by her PCP on patient appointment, to and to get prescriptions for a psychology referral the guardian was the only	C 246			

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and incident reports revealed there were no

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL011022	B. WING		ı	R / 25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
FAIRVIEW	/ FAMILY CARE HOME #		VELY BRANCH RO	DAD		
174IIVILVI	TAIMET GARE HOME #	FLETCH	ER, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
C 246	Continued From page	÷ 13	C 246			
	progress notes or inci	ident reports available.				
	10:00am revealed: -Resident #1 smoked -Resident #1 "hung of bumming cigarettes at -Resident #1 rarely cat -Resident #1 rarely cat Interview with the Adr 2:48pm revealed: -She never pursued at because "that was the -She left a voice mail about the need for a procall was not returned -Resident #1 needed because she would downen she had an extinand, was smearing from smoking in her room affire alarm in the middle cigarettes in the close	ame out of her room. ministrator on 06/23/21 at a psychology referral e guardian's job". message for the guardian osychology referral but the for 2 weeks.				
	06/25/21 at 1:26pm re	(SIC) at a sister facility on evealed a family member aking messages from the chine because the				
	for one resident which on 04/30/21 and origin exit date of 05/03/21 ther closet as a bathro	btain a psychology referral n was ordered by her PCP nally cited in a survey with for Resident #1 who used som and smeared feces on t; she refused to come out of ntly isolated herself;				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		FCL011022	B. WING		06	R 5 /25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FAIRVIEW	/ FAMILY CARE HOME #	11	AVELY BRANCH RO IER, NC 28732	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 246	continued to smoke three verbal warning and extinguished he incontinent briefs, the off the fire alarm in the failure resulted in sean Unabated Type A	nside the facility despite s and two written warning r cigarettes on her e carpet, windowsill and set ne middle of the night. This rious neglect and constitutes	C 246			
C 315	10A NCAC 13G .100 (a) A family care how the resident's physic for verification or class medications and treat (1) if orders for admiresident are not date of admission or read (2) if orders are not (3) if multiple admission or readmiforms are not the sar The facility shall ens	ssion or readmission of the d and signed within 24 hours mission to the facility; clear or complete; or ion forms are received upon ssion and orders on the	C 315			
	reviews, the facility for care physician (PCP) (Resident #2) related orders for a medicati	as evidenced by: ns, interviews, and record ailed to contact the primary) for 1 of 3 sampled residents it to clarification of medication on to treat benign prostatic and a medication used to treat				

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DIVISION	n nealth Service Negu	ilalion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
						_
			D WING		F	
		FCL011022	B. WING		06/2	25/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE		
			ELY BRANCH			
FAIRVIEW	FAMILY CARE HOME #	1	R, NC 28732	NOAD		
			K, NC 20732	1		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		DATE
17.0		,	170	DEFICIENCY)		
C 315	Continued From page	e 15	C 315			
	The findings are:					
	The illiangs are.					
	Review of Resident #	2's current FL2 dated				
	02/10/21 revealed dia					
	hypotension, depress	~				
	hyperplasia (BPH) wit					
	hypothyroidism, and	- · · · · · · · · · · · · · · · · · · ·				
	hypothyroldisin, and s	Shorthess of breath.				
	a Review of Residen	it #2's current FL2 dated				
	02/10/21 revealed a p					
	·	reat BPH) 0.5mg take 1				
	capsule daily.					
	Davious of a pharman	v dalivary tiakat for Basidant				
		y delivery ticket for Resident				
	#2 dated 01/22/21 rev					
		ts of finasteride 5 mg (used				
	•	ablet daily delivered to the				
	facility on 01/22/21.					
		e medication label included a				
		ion "replaces dutasteride."				
	•	nation why the finasteride				
	replaced the dutaster	ide.				
	D : (D ::	101 1 0004 14 17 17				
		2's June 2021 Medication				
	Administration Record					
	•	for dutasteride 0.5mg take 1				
	-	led to be administered at				
	8:00am daily.					
		eride was crossed out with a				
	handwritten note "cha					
		stion mark beside the date.				
		umented as administered				
	from 06/01/21 to 06/1					
	-There was no entry f	for finasteride.				
	Observation of Reside	ent #2's medication on hand				
	on 06/23/21 at 11:09a	am revealed:				
	-There was no dutast	eride 0.5mg available to be				

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administered.

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DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			1		1 _	_
			D 14//10		F	
		FCL011022	B. WING		06/2	25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE ZIP CODE		
TVAIVIL OF T	TOVIDER OR OUT FIELD					
FAIRVIEW	FAMILY CARE HOME #	1	ELY BRANCH	ROAD		
		FLETCHE	R, NC 28732			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
				DEI IOIEITOT)		
C 315	Continued From page	e 16	C 315			
	-There was a bottle of	f finasteride 5mg with a fill				
	date of 06/10/21 avail	lable to administer.				
	-The finasteride was i	not dispensed from the				
	facility's contracted pl	harmacy.				
	,	•				
	Telephone interview v	vith a pharmacy technician				
	from the facility's conf					
	06/23/21 at 10:00am					
		of dutasteride 0.5mg were				
	=	nt #2 as an emergency fill.				
		ets of dutasteride 0.5mg				
	were dispensed to Re					
	-	ot have a current order with				
	refills for dutasteride.					
	-The pharmacy had n	ever filled finasteride for				
	Resident #2.					
	Interview with Reside	nt #2 on 06/23/21 at 3:30pm				
	revealed:					
	-He was having a har	d time sleeping at night over				
	_	ise he had to get up and go				
	to the restroom so ma					
		uld have to get up 6 to 7				
	times to go to the resi	.				
	unics to go to the res	aroom.				
	Interview with a forme	er supervisor-in-charge (SIC)				
		,				
	at a sister facility on 0	10/23/21 at 12.03pm				
	revealed:					
		for clarifying medication				
	orders for the residen					
		ting medications from three				
	•	and seeing several different				
	physicians.					
	-Resident #2 got som	e of his medications filled at				
	another pharmacy be	sides the facility's				
	contracted pharmacy					
		Resident #2's primary care				
		t he was out of town and				
	-					
	she could not get the	oruer Garineu.	1			

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-She thought the finasteride was supposed to

STATE FORM 6899 RDFT11 If continuation sheet 17 of 48

Division	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	FD
					R	
		FCI 044022	B. WING			10004
		FCL011022	B: Wilto		06/25/	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		256 GRA\	ELY BRANCH I	ROAD		
FAIRVIEW	FAMILY CARE HOME #	1	R, NC 28732	TOAD		
			111, 140 20732	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
			1			
C 315	Continued From page	e 17	C 315			
	replace the dutasterio	de because of the				
	•	she did not have an order				
	stating this.					
	-She did not know wh	ov the finasteride was				
	supposed to replace					
	-Resident #2 was not					
		s BPH because the order				
	was not clarified.	s Drii because tile oldel				
	was not claimed.					
	Tolonhono intonvious	with a nurse from Resident				
		vider's (PCP) office on				
		` ,				
	06/24/21 at 3:33pm re					
		scribed dutasteride to treat				
	his BPH.	r e e e				
		ed as an active medication				
	for Resident #2.	31. ((III. D))				
		nsible for refilling Resident				
	#2's medication for B					
		prescribed finasteride to				
	Resident #2.					
		ive received the finasteride				
	from another provider	r.				
		ministrator on 06/23/21 at				
	3:03pm revealed:					
		a family member to help				
		ation orders were correct.				
	-The former SIC did h	•				
	medication orders up					
		working to get the orders				
	clarified.					
		nat medications the residents				
	were supposed to be	administered.				
		t #2's current FL2 revealed				
		r pantoprazole (used to treat				
	heart burn) 40mg take	e 1 tablet twice daily.				
	Observation of Resid	ent #2's medication on hand				

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at 11:09am on 06/23/21 revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
		FCL011022	B. WING		R 06/25/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	1	VELY BRANCH	ROAD		
			ER, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPI	LETE
C 315	Continued From page	÷ 18	C 315			
C 315	-There was no pantop administeredThere was a bottle of take 1 tablet daily fille #2's pharmacyThe rabeprazole was contracted pharmacy. Review of Resident # revealed there was no rabeprazole 20mg take. Telephone interview of from the facility's conto 06/23/21 at 10:00am -The pharmacy last dipantoprazole 40mg to -The pharmacy had no discontinue the panto -The pharmacy did no for rabeprazole for Resident #2's pharmacy revealed the pharmacy rabeprazole 20mg to Review of Resident # Administration Record -There was an entry for tablet twice daily so at 8:00am and 8:00pr -The entry for pantopia note written beside	prazole available to be containing rabeprazole 20mg d on 06/22/21 at Resident a not filled by the facility's 2's record on 06/23/21 o physician's order for a 1 tablet daily. with a pharmacy technician tracted pharmacy on revealed: ispensed 34 tablets of a Resident #3 on 02/25/21. ot received an order to prazole. ot have a medication order esident #3. with a pharmacist from acy on 06/25/21 at 11:04am by dispensed 30 tablets of Resident #2 on 06/22/21. 2's June 2021 Medication d (MAR) revealed: or pantoprazole 40mg take heduled to be administered in daily. rezole was crossed out with	C 315			
	to 06/18/21.	and 8:00pm from 06/01/21 or rabeprazole 20mg take 1				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BOILDING.		R	
		FCL011022	B. WING		1	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	1	LY BRANCH I	ROAD		
		FLETCHER	, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 315	Continued From page	e 19	C 315			
	Interview with Reside revealed he knew his changed by his prima	nt #2 on 06/23/21 at 3:30pm acid reflux medication was ry care provider (PCP) but e of the new medication.				
	o6/23/21 at 12:05pm -She was responsible orders for the residen -Resident #2 was get different pharmacies a physiciansShe removed all med supply of medications a current orderResident #2's was not rabeprazole 20mg be have a current order full-she did not know if the take the pantoprazole	e for clarifying medication ts in the facility. ting medications from three and seeing several different dications from the resident's that the facility did not have of administered the cause the facility did not for the medication. the resident was supposed to				
	#2's primary care pro 3:33pm revealed: -The pantoprazole wa -The resident was sup rabeprazole for his ac	oid reflux. nave increased discomfort				
	3:03pm revealed: -She had reached out make sure the medica -The former SIC did h medication orders upo	•				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL011022	B. WING		06	R 5/ 25/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 00	72072021
		256 GRA\	/ELY BRANCH			
FAIRVIEW	FAMILY CARE HOME #	1 FLETCHE	R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 315	Continued From page	20	C 315			
	clarifiedShe did not know wh were supposed to be	at medications the residents administered.				
C 330	10A NCAC 13G .1004 Administration	4(a) Medication	C 330			
	(a) A family care hom preparation and admi prescription and non-by staff are in accorda (1) orders by a license which are maintained	4 Medication Administration ne shall assure that the nistration of medications, prescription and treatments ance with: ed prescribing practitioner in the resident's record; and on and the facility's policies				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews the facility fai medications as order residents (Residents medication to treat an schizophrenia (Residents)	ed for 2 of 3 sampled #1 and #2) related to a				
	The findings are:					
	02/10/21 revealed dia hypotension, depress hyperplasia (BPH) wii hypothyroidism, and s	ion, benign prostatic th urinary frequency,				

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DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			D WING		R
		FCL011022	B. WING		06/25/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE	
			ELY BRANCH I		
FAIRVIEW FAMILY CARE HOME # 1		R, NC 28732	TOAD		
			T, NC 20732		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
IAO		,	IAG	DEFICIENCY)	
			0.000		
C 330	Continued From page	e 21	C 330		
	02/10/21 revealed a p	hysician's order for			
	dutasteride (used to t	reat BPH) 0.5mg take 1			
	capsule daily.				
		2's June 2021 Medication			
	Administration Record				
	•	or dutasteride 0.5mg take 1			
		led to be administered at			
	8:00am daily.				
	_	eride was crossed out with a			
		de the medication name			
	_	le 01/22/21" with a question			
	mark beside the date.				
		umented as administered			
	from 06/01/21 to 06/1	8/21 at 8:00am daily.			
	Observation of Reside	ent #2's medication on hand			
	on 06/23/21 at 11:09a	am revealed there was no			
		ailable to be administered.			
	Telephone interview v	vith a pharmacy technician			
	from the facility's cont	tracted pharmacy on			
	06/23/21 at 10:00am	revealed:			
	-The pharmacy had la	ast dispensed 5 tablets of			
	dutasteride 0.5mg to	Resident #3 on 06/16/21 as			
	an emergency fill.				
		e last time the pharmacy had			
	filled dutasteride 0.5m	ng to Resident #3 was			
		lets were delivered to the			
	facility.				
	-The pharmacy did no	ot have a current order with			
	refills for dutasteride.				
	Interview with Reside	nt #2 on 06/23/21 at 3:30pm			
	revealed:	m π2 on ου/20/21 at 3.30μm			
	-He was having a har	d time sleeping at night over			
	the past month becau	se he had to get up and go			
	to the restroom so ma	any times.			
	-Some nights, he wou	uld have to get up 6 to 7			

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times to go to the restroom.

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STATEMENT OF DEFICIE	NCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECT	ION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			1		
		FCL011022	B. WING		R 06/25/2021
NAME OF PROVIDED OR	CURRUER		DECC CITY CTA	TE ZID CODE	1 00/20/2021
NAME OF PROVIDER OR	SUPPLIER		DRESS, CITY, STA		
FAIRVIEW FAMILY C	ARE HOME #	1	ELY BRANCH I	ROAD	
		FLETCHE	R, NC 28732		
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 330 Continue	d From page	e 22	C 330		
sister facility -She help medicatic was adm -Residen different physiciar -Residen to his app -She did residents received -She rem from the facility did to the facilit	ility on 06/23 ninistrator way. Deed the Adm on orders to inistered the t #2 was get charmacies as. t #2 was ind cointments. not administ but did not any medicat oved all mer resident's su d not have a e interview was contracted pl evealed Resid d urinary co ered the duta e interview was ary care pro at 3:33pm re t #2 was pre ide was liste ent #2. De was respon ication for B t #2 was at re	with a nurse from Resident vider's (PCP) office on evealed: escribed dutasteride to treat ed as an active medication			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		FCL011022	B. WING		R 06/25/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
FAIRVIEW	FAMILY CARE HOME #	1	ELY BRANCH	ROAD	
			ER, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 330	Continued From page	23	C 330		
	Refer to the interview supervisor-in-charge 06/23/21 at 3:03pm.				
		e interview with a pharmacy cility's contracted pharmacy n.			
	Refer to the telephone interview with the Nurse Consultant on 06/23/21 at 12:15pm.				
	Refer to the interview 06/23/21 at 12:40pm.	with the Administrator on			
	hand at 11:09am on 0 a bottle containing ral	sident #2's medication on 06/23/21 revealed there was peprazole (used to treat flux) 20mg take 1 tablet 1 at Resident #2's			
		2's record on 06/23/21 o physician's order for ce 1 tablet daily.			
	from the facility's cont 06/23/21 at 10:00am	vith a pharmacy technician tracted pharmacy on revealed the pharmacy did n order for rabeprazole for			
	Resident #2's pharma	with a pharmacist from acy on 06/25/21 at 11:04am by dispensed 30 tablets of Resident #2 on 06/22/21.			
	Administration Record	2's June 2021 Medication d (MAR) revealed there was ble 20mg take 1 tablet daily.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	,
		FCL011022	B. WING			5/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	1	ELY BRANCH I	ROAD		
FLETCHI			R, NC 28732		Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	Continued From page	e 24	C 330			
	revealed his heartbur	ent #2 on 06/23/21 at 3:30pm n was "okay" today bothering him some over the				
	sister facility on 06/23 -She helped the Adm medication orders to was administered the -Resident #2 was get different pharmacies a physiciansShe removed all med supply of medications a current orderResident #2's was no	ting medications from three and seeing several different dications from the resident's s that the facility did not have ot administered the cause the facility did not				
	#2's primary care pro 3:33pm revealed: -The resident was su rabeprazole for his ac	cid reflux. nave increased discomfort				
	Refer to the interview supervisor-in-charge 06/23/21 at 3:03pm.					
		e interview with a pharmacy acility's contracted pharmacy m.				
	Refer to the telephon	e interview with the Nurse				

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		FCL011022	B. WING		R 06/25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
EAID\/IE\A	FAMILY CARE HOME #	256 GRAVE	ELY BRANCH F	ROAD	
FAIRVIEW	FAMILY CARE HOME #	1 FLETCHER	R, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 330	Continued From page	± 25	C 330		
	Refer to the interview 06/23/21 at 12:40pm.	with the Administrator on			
	Refer to the telephone interview with the Administrator on 06/25/21 at 1:26pm.				
	04/30/21 revealed: -Diagnoses included moderate intellectual	t #1's current FL2 dated paranoid schizophrenia, disability and tobacco use. for lorazepam 0.5mg, 1			
	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.				
	four times a day. -The order specified a refills. -There was a piece of lorazepam tablets we when she was discha				
	from the facility's cont 06/23/21 at 11:11am -The pharmacy receiv #1's FL2 dated 03/03, -On the FL2 there wa 0.5mg, four times a d -They dispensed 12 to dose because they no the primary care prov	revealed: ved a faxed copy of Resident /21. is an order for lorazepam ay. ablets as an emergency eeded a prescription from			

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DIVISION	n nealth Service Regu	ialion				_
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1	_		
	ECI 011022 B. WING		R			
		FCL011022	B. WING		06/25/2021	_
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			ELY BRANCH I			
FAIRVIEW	FAMILY CARE HOME #	1	R, NC 28732	TOAD		
		FLETCHE	K, NC 20/32			_
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(- /	
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		
TAG	THE COLUMN TOTAL	is in the initial or	TAG	DEFICIENCY)		
			+			\dashv
C 330	Continued From page	e 26	C 330			
	hard copy of the pres	orintian which thay				
		armacy never received one				
	from either the facility					
	-The pharmacy receiv					
	prescription from the					
	lorazepam 0.5mg fou					
		nsed a 30-day supply (120				
		0.5mg on 05/03/21 and it				
	was delivered to the f	•				
	-The 30-day supply of	f lorazepam should have				
	lasted through 06/02/2	21.				
	-The pharmacy conta	cted the PCP on 06/09/21				
	for a refill but the PCF	odenied the refill request,				
	stating Resident #1 n	eeded to be seen by the				
	PCP before she would					
	Review of Resident #	1's May 2021 Medication				
	Administration Record					
		for lorazepam 0.5mg, 1				
	tablet 4 times a day.	or lorazopam olomg, r				
	-The lorazepam was	documented as				
		es a day from 05/04/21 to				
	05/31/21.	cs a day 110111 00/04/21 to				
	00/01/21.					
	Review of Resident #	1's June 2021 MAR				
	revealed:	10 Julio 2021 IVIAIX				
		for lorazepam 0.5mg, 1				
	_	or lorazepain u.omy, I				
	tablet 4 times a day.	degumented as				
	-The lorazepam was					
		es a day from 06/01/21 to				
	06/16/21.	d				
	-The lorazepam was					
	administered twice or	า 06/17/21.				
		ministrator on 06/23/21 at				
	12:10pm and 2:48pm					
		tion aide for the facility.				
		" had lorazepam available				
	and she administered	I it 4 times a day until she				

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was discharged on 06/17/21.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
	FCL011022 B. WING		R 06/25/2021			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	1	LY BRANCH F	ROAD		
	Г	FLETCHER	, NC 28732		Т	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	2 7	C 330			
	-All medications were contracted pharmacy -She did not use a ba medications for Residual and the same dications were she was discharged, piece of paper that was supervisorShe did not remember were sent with Residual and the same dications of inappropriate in her room, smoking against policy, extingual flammable items and	e delivered from the facility's , usually a 90-day supply. lock up pharmacy to get any lent #1. e sent with Resident #1 when and they were listed on a as given to the guardian's ler how many lorazepam lent #1. d the guardian obtain a lecause Resident #1's oriately using the bathroom in her room which was				
	PCP's office on 06/24 -Resident #1 was pre anxiety related to her -A prescription for lora days and required a frefillsLorazepam was a mataperedIf Resident #1 did no ordered she could ha worsening schizophre trouble sleeping, rebo seizures or irritabilityResident #1 did not ha appointments to be se Telephone interview w 06/25/21 at 1:26pm re understand what hap	nave any pending een by the PCP. with the Administrator on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING: _		OOMI LETED
		FCL011022	B. WING	R 3 06/25 /	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE ZIP CODE	
			/ELY BRANCH R		
FAIRVIEW	FAMILY CARE HOME #	1	R, NC 28732	ionb	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 330	Continued From page	28	C 330		
	to administer.				
	Refer to the interview supervisor-in-charge 06/23/21 at 3:03pm.				
	_ ·	e interview with a pharmacy cility's contracted pharmacy n.			
	Refer to the telephone Consultant on 06/23/2	e interview with the Nurse 21 at 12:15pm.			
	Refer to the interview with the Administrator on 06/23/21 at 12:40pm.				
	Refer to the telephone Administrator on 06/2				
	sister facility on 06/23 -She completed medi Administrator.	er supervisor-in-charge at a 6/21 at 3:03pm revealed: cation audits weekly for the audit was completed the			
	-She compared the N available to administe medication orders in a	IAR to the medications or and the MAR to the each resident's record.			
	month or two to make were accurate.	sure all medication orders			
	did not match the med facility for administrat -She was responsible pharmacy and updati	dications available in the ion for some residents. If or faxing orders to the ing the MAR when a new			
	-She was responsible physician for new refi	received for a resident. for calling a resident's lls. each resident's primary care			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		FCL011022	B. WING		R 06/25/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
EAID\/IE\A	FAMILY CARE HOME #	256 GRAV	ELY BRANCH I	ROAD	
FAIRVIEW	PAMILI CARE HOME #	FLETCHE	R, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 330	Continued From page	29	C 330		
	provider (PCP) for ne	w refills.			
	from the facility's com 06/23/21 at 1:23pm re -The facility was resp orders to the pharmac the order directly to the -The pharmacy was resident's physician fe -The pharmacy would a resident's physician received a response a refill the medication to Telephone interview v 06/23/21 at 12:15pm -She was responsible quarterly medication	evealed: consible for faxing medication cy unless the physician sent ne pharmacy. esponsible for faxing a cor refills. I notify the facility to contact for refills if they had not and it was almost time to to be sent in the cycle fill. with the Nurse Consultant on revealed: for completing the facility's reviews.			
	-The facility had conta	acted her to come to the emedications about 7 to 10			
	days agoShe visited the facilit completed a medicati	y on 06/21/21 and on review for each resident. onsible for following up on s with each resident's ach resident was			
	12:40pm revealed: -She was the medica: -She did not know whadministered to the reShe did not know if ecorrect medications of	each resident was getting the			
		evealed she was responsible			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				06/			
		FCL011022	B. WING		06/2	5/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
FAIRVIEW	FAMILY CARE HOME #	256 GRAVE	LY BRANCH I	ROAD			
		FLETCHER	R, NC 28732		ı		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
C 330	Continued From page	÷ 30	C 330				
	ordered including Restreat anxiety associate increasing her risk of schizophrenic episode failed to administer du prostatic hyperplasia resulting in Resident areach night to urinate a rabeprazole as ordere (Resident #2) increas heartburn and discord detrimental to the hear residents and constitution.	#2 getting up multiple times and failed to administer ed to treat acid reflux ing his risk of experiencing ufort. These failures were					
C 341	(i) The recording of the medication administrated staff person who adminmediately following medication to the resi	4 Medication Administration The administration on the lation record shall be by the linisters the medication administration of the lation and observation of the lation and prior of another resident's	C 341				
		as evidenced by: ews interviews the facility he staff who administered a					

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	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU		
			A. BUILDING: _		_		
		FCL011022	B. WING	l l		R 6/ 25/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
		256 GRAV	ELY BRANCH F	ROAD			
FAIRVIEW	/ FAMILY CARE HOME #	1 FLETCHE	R, NC 28732				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
C 341	Continued From page	e 31	C 341				
	the administration on Administration Recor						
	Administration Recon- The Administrator's sethe MAR looked differsignature on other double administrator's in administration of media from the Administration documents at the factories with the Administration of media to the control of the contro	signature at the bottom of rent from the Administrator's cuments at the facility. nitials documenting lications looked different r's initials on other					
	at a sister facility on 0 revealed: -She never touched the control of the control	er supervisor-in-charge (SIC) 26/23/21 at 11:54am the MAR. as the only person at the n the MAR. at a sister facility on 06/25/21 lied on a former SIC to help administration. resident medications in a rator administered the					

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the MAR by signing the Administrators initials.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		FCL011022	B. WING		06/25/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	256 GRAV	ELY BRANCH I	ROAD		
17411411211	TAMIET GARE HOME #	FLETCHER	R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 341	Continued From page	e 32	C 341			
	MAR, "she was not be-She was able to tell to Administrator signed signed for the Adminis-The former SIC had AdministratorShe remembered it in the evening of 06/21/2 Interview with the AdministratorShe did not deny any told the surveyorThe former SIC documents.	the difference in how the and how the former SIC strator. no authority to sign for the most recently being done on				
C 342	(j) The resident's merecord (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa medication administe (4) instructions for ador treatment; (5) reason or justifical medications or treatmed documenting the result (6) date and time of a (7) documentation of medications or treatmomission, including reference (8) name or initials of	4 Medication Administration dication administration e accurate and include the cation or treatment order; age or quantity of red; ministering the medication tion for the administration of nents as needed (PRN) and alting effect on the resident; administration; any omission of nents and the reason for the	C 342			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL011022		A. BOILDING.		R	
		FCL011022	B. WING		06/25/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	256 GRA	ELY BRANCH F	ROAD		
TAIRVIEV	TAMIET GARE HOME #	FLETCHE	R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 342	Continued From page	e 33	C 342			
	•	to those initials is to be ntained with the medication (MAR).				
	reviews the facility fai Administration Record of 3 sampled resident related to a medication	ns, interviews and record led to ensure the Medication d (MAR) was accurate for 2 ts (Residents #1 and #2) on to treat anxiety (#1) and benign prostatic hyperplasia				
	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.					
		1's Resident Register dated e was admitted to the facility				
	four times a dayThe order specified a refillsThere was a paper d tablets were sent with discharged on 06/17/2-There was no docum	dated 05/03/21 for tion to treat anxiety) 0.5mg a 30-day supply with no locumenting 5 lorazepam a Resident #1 when she was 21. nentation Resident #1 m from her previous facility				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
	FCL011022 B. WING		06/2	5/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	•	
FAIRVIEW FAMILY CARE HOME # 1	1	ELY BRANCH I R, NC 28732	ROAD		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
from the facility's control 06/23/21 at 11:11am in The pharmacy receives prescription from the F (PCP) on 05/03/21 for times a day and specirablets) of lorazepam (was delivered to the father of the	with a pharmacy technician racted pharmacy on evealed: ed an electronic Primary Care Provider I lorazepam 0.5mg four fied no refills. Insed a 30-day supply (120 0.5mg on 05/03/21 and it acility on 05/04/21. I lorazepam should have 21. Interest the PCP on 06/09/21 of denied the refill request, eeded to be seen by the diauthorize a refill. It's May 2021 Medication of (MAR) revealed: In lorazepam 0.5mg, 1 I documented as a day from 05/04/21 to the control of the control	C 342			

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-She always had lorazepam available to

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 256 GRAVELY BRANCH ROAD FLETCHER, NC 28732 [CA) ID PREFIX TAG GAH OF FROM LIST GENERAL STREED AND THE PRECEDED BY FULL TAG C 342 C Onttinued 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 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 12:05pm. Refer to the interview with the Administrator on 06/23/21 at 12:05pm. Refer to the interview with the Administrator on 06/23/21 at 12:05pm. 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.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SUF COMPLET	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 256 GRAVELY BRANCH ROAD FLETCHER, NC 28732 [X4) ID PREFIX ILEACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 C Ontinued 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 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 12:40pm. 2. Review of Resident #2's current FL2 dated 02/10/21 revealed diagnoses included hypotension, depression, benign prostatic hyperplasia (BPH) with urinary frequency,				A. BOILDING.			
PAIRVIEW FAMILY CARE HOME # 1 (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 C 342 C 342 C 342 C 342 C 342 C 343 C 344 C 345 C 345 C 345 C 345 C 345 C 346 C 346 C 346 C 347 C 347 C 348 C 3			FCL011022	B. WING			/2021
(24) D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PREFICED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 342 C Ontinued From page 35 administerShe 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 timeShe 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 12:40pm. 2. Review of Resident #2's current FL2 dated 02/10/21 revealed diagnoses included hypotension, depression, benign prostatic hyperplasia (BPH) with urinary frequency,	NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION AUGULO BE CROSS-REFERENCED TO THE APPROPRIATE DATE	FAIRVIEW	V FAMILY CARE HOME #	1		ROAD		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (COMPLETE DATE (ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (COMPLETE DATE (ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE (COMPLETE DATE (ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (COMPLETE DATE (ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (COMPLETE DATE (COMPLETE DATE (ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE (COMPLETE DATE (COMPLETE DATE (ACTION SHOULD BE CROSS-REFERENCED TO HE APPROPRIATE (COMPLETE DATE (COMPLETE DATE		T		·			
administerShe 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 timeShe did not know a refill request had been deniedShe 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,	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
-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 timeShe did not know a refill request had been deniedShe 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,	C 342	Continued From page	e 35	C 342			
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 dailyThe entry for dutasteride was crossed out with a	C 342	administerShe did not know the 05/03/21 was written not have a refill; she to three months at a time. She did not know a redeniedShe did not know who 06/17/21 if her 30-day on 06/02/21. Refer to the telephone technician from the factor on 06/23/21 at 1:23pr. Refer to the interview supervisor-in-charge 06/23/21 at 12:05pm. Refer to the interview 06/23/21 at 12:40pm. 2. Review of Residen 02/10/21 revealed dialy hypotension, depress hyperplasia (BPH) with hypothyroidism, and seed a period of the capsule daily. Review of Resident #Administration Recorder. There was an entry for capsule daily schedul 8:00am daily.	e lorazepam order written on for a 30-day supply and did thought it was delivered e. refill request had been by she still had 5 tablets on y supply would have run out e interview with a pharmacy acility's contracted pharmacy m. with a former (SIC) at a sister facility on with the Administrator on the t#2's current FL2 dated agnoses included sion, benign prostatic th urinary frequency, shortness of breath. It #2's current FL2 dated by sician's order for reat BPH) 0.5mg take 1	C 342			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SU		
,		.52	A. BUILDING:			
		FCL011022	B. WING		06/2	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
EAID\/IE\A	ZEAMILY CARE HOME #	256 GRAVE	ELY BRANCH I	ROAD		
FAIRVIEW FAMILY CARE HOME # 1 FLETCHE			R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page	e 36	C 342			
	"changed to finasteric mark beside the date	de 01/22/21" with a question umented as administered				
	on 06/23/21 at 11:09a	ent #2's medication on hand am revealed there was no ailable to be administered.				
	from the facility's cont 06/23/21 at 10:00am -The pharmacy had d dutasteride 0.5mg to an emergency fill. -Prior to 06/16/21, the filled dutasteride 0.5m	revealed:				
	refills for dutasterideThe pharmacy had a	ot have a current order with note to not fill medications s it was for an emergency				
	at a sister facility on 0 revealed she did not a	administer any medications id not think Resident #2 had				
	-	e interview with a pharmacy cility's contracted pharmacy n.				
	Refer to the interview sister facility on 06/23	with as former SIC at a 3/21 at 12:05pm.				
	Refer to the interview 06/23/21 at 12:40pm.	with the Administrator on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
741012741	or dorate of the transfer of t	ISENTI IOMINENTALIA	A. BUILDING:		R	
		FCL011022	B. WING	B. WING		2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	256 GRAV	ELY BRANCH I	ROAD		
TAIRVILV	TAMILI CARL HOME#	FLETCHE	R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICE DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 342	Continued From page	e 37	C 342			
		t #2's current FL2 revealed r pantoprazole (used to treat e 1 tablet twice daily.				
	Administration Record -There was an entry for 1 tablet twice daily so at 8:00am and 8:00pr -The entry for pantop a note written beside -Pantoprazole was do	or pantoprazole 40mg take heduled to be administered m daily. razole was crossed out with				
		ent #2's medication on hand 21 revealed there was no le to be administered.				
	from the facility's con 06/23/21 at 10:00am -The pharmacy dispe pantoprazole 40mg to	revealed: nsed 34 tablets of p Resident #2 on 02/25/21. not received an order to				
		e interview with a pharmacy acility's contracted pharmacy m.				
	Refer to the interview supervisor-in-charge 06/23/21 at 12:05pm.	at a sister facility on				
	Refer to the interview 06/23/21 at 12:40pm.	with the Administrator on				
	Telephone interview v	 with a pharmacy technician				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING	7. Bolesine.		
		FCL011022 B. WING			R 06/25/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
EAID\/IE\A	A FAMILY CARE HOME #	256 GRAV	ELY BRANCH F	ROAD		
FAIRVIEW FAMILY CARE HOME # 1 FLETCHE			R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page	e 38	C 342			
C 342	from the facility's con 06/23/21 at 1:23pm re- The pharmacy printe Administration Recorbin the facility monthly facility. The MARs were prine- The facility was responsections on the Mark to the pharmacy monomake corrections to tender of the facility never second or the facility never second or the facility on 06/23. The facility on 06/23 are corrections back to the linear with the facility on 06/23. The helped the Admines were correct for the MARs were correct for the MARs weekly. She was responsible the MAR when a resion order. Sometimes the pharmacy of the Mark medication change. She did not know whisigning off that she has that were not available linterview with the Admines was responsible MAR when she admines dent. She did not know when she did not	tracted pharmacy on evealed: ed a paper Medication of (MAR) for all the residents and delivered them to the sted on a triplicate form. onsible for making AR and sending a copy back thly for the pharmacy to the MAR. In the form to make the MAR the pharmacy. er supervisor-in-charge at a 8/21 at 12:05pm revealed: inistrator make sure the or each resident by auditing the for making corrections to dent had a new medication of macy would send an MAR to the facility after a send administrator was ad administered medications the in the facility. The for documenting on the inistered a medication to a send the send of the matter of the mistered and the send of the mistered she had documented she send the mistered she was a send administered and the mistered she was a send administered the mistered and the mistered she was a send administered and the mistered she was a send administered medication to a send the mistered and the mistered she was a send administered and the mistered she was a send administered and the mistered she was a send and the mistered and the mistered she was a send and the mistered she w	C 342			
	that she did not have -She knew she was s	dications to the residents available to administer. suppose to sign on the MAR				

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know what she was administering.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R
		FCL011022	B. WING		06/25/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FAIRVIEW	FAMILY CARE HOME #	256 GRAVI	ELY BRANCH I	ROAD	
Allevieve	TAMIET GARE HOME #	FLETCHER	R, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 367	10A NCAC 13G .1008 (a) A family care hom retrievable record of of documenting the recedisposition of controller records shall be main record and in such an accurate reconciliation. This Rule is not met Based on interviews a facility failed to maintain receipt and administration.	as evidenced by: and record reviews the ain accurate records of ation of a controlled olled Substance Count	C 367		
	, ,	to a medication to treat			
	Review of Resident # 04/30/21 revealed: -Diagnoses included moderate intellectual	1's current FL2 dated paranoid schizophrenia, disability and tobacco use. for lorazepam 0.5mg, 1			
	03/03/21 revealed she	1's Resident Register dated e was admitted to the facility narged to another facility on			
	four times a day.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	A. BUILDING:			COMP	PLETED
						R
		FCL011022	B. WING		06	/25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
= 4 IB\ (IE\ 4	, =	256 GRA	VELY BRANCH I	ROAD		
FAIRVIEW	FAMILY CARE HOME #	1 FLETCH	ER, NC 28732			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
C 367	Continued From page	e 40	C 367			
	refills.					
		f nanar dagumenting F				
	· ·	f paper documenting 5				
		ere sent with Resident #1				
		arged from the facility on				
	06/17/21.					
	Review of Resident #	t1's June 2021 Medication				
	Administration Recor					
		for lorazepam 0.5mg, 1				
	tablet 4 times a day.	ior iorazopam o.omg, i				
		umented as administered				
	-	06/01/21 to 06/16/21.				
	_	umented as administered				
	twice on 06/17/21.	unicitied as administered				
	twice on 60/17/21.					
	Review of Resident #	t1's controlled substance				
	count sheet (CSCS)	revealed:				
	-There was a CSCS	for lorazepam 0.5mg, 1				
	tablet 4 times a day t	hat was started on 05/29/21.				
	-The CSCS documer	nted 60 of the 120 lorazepam				
	that were dispensed	in 2 bubble packs.				
	-Lorazepam was doc	umented as administered 4				
	times a day from 05/2	29/21 through 06/04/21.				
	-	umented as administered 8				
	times on 06/05/21.	umonted as administers d 4				
	times on 06/06/21.	umented as administered 4				
	-Lorazepam was doc times on 06/07/21.	umented as administered 2				
		umanted as administered 4				
	-	umented as administered 4 08/21 through 06/16/21.				
		umented as administered 2				
	times on 06/17/21.	umenteu as aunimistereu z				
		ce column was left blank on				
	the entire CSCS.	Ce COIUIIIII WAS IEIL DIAIIK UII				
		nted 80 doses administered.				
		of declining numbers				
		S .				
	_	that started at 45 and ended				
		document the declining				
	balance.		1			

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		_
	FCL011022	B. WING		R 06/25/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FAIRVIEW FAMILY CARE HOME # 1		ELY BRANCH F R, NC 28732	ROAD	
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
on 05/30/21 was a reper documented on 05/29/2 -The declining balance on 06/03/21 was a reper documented on 06/02/2 -The declining balance a balance of 8. Telephone interview with the facility's contract phe 11:11am revealed: -The pharmacy receive #1's FL2 dated 03/03/2 -The FL2 documented a 0.5mg, four times a day and of the primary care provided a 0.5mg lorazepam on 03 dose because they need the primary care provided a care provided a factor of the PCP on 05/03/21 for times a day and it was del 05/03/21 and it was del 05/04/21The pharmacy dispensional transport of the primary care provided by 15/03/21 and it was del 05/04/21The pharmacy dispensional provided by 15/03/21 and it was del 05/03/21The 30-day supply of the 05/03/21 should have be 15/03/21 should have be 15/03/21 should have be 25/03/21 should have be 25/03/21. Interview with the Admit 10:45am and 11:54am and 11:54am and 5/28. Complete a CSCS for loone on 05/29/21.	of 43 tablets documented eat of the count 21. of 28 tablets documented eat of the count 21. stopped on 06/07/21 with 21. stopped on 06/07/21 with 22. stopped on 06/23/21 at 23. d a faxed copy of Resident 21. an order for lorazepam 24. solets, a 3-day supply, of 3/03/21 as an emergency 25. ded a prescription from 26. der (PCP). d an e-prescription from 27. sed a 30-day supply (120 ks) of lorazepam 0.5mg on 28. livered to the facility on 28. sed a total of 132 tablets of 29. der (PCP) and 3/03/21 and 3/03/21 and 3/03/21 and 3/03/21 and 3/03/21. der (PCP) and an e-prescription from 3. der a supply (120 ks) of lorazepam 0.5mg on 3/03/21 and 3/03/21 at 20.	C 367	DETICIENCY)	

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			(X3) DATE SURVEY
AND LEMY OF CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COMPLETED
				R
	FCL011022			06/25/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STAT	TE ZIR CODE	, , , , , , , , , , , , , , , , , , , ,
NAME OF TROVIDER OR SOFT EIER				
FAIRVIEW FAMILY CARE HOME # 1		LY BRANCH F	ROAD	
	FLETCHER	, NC 28732		
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
C 367 Continued From page 42	2	C 367		
-She had never been train a CSCSShe did not know why 06 times, indicating 8 doses -She did not give a "doub-Resident #1 always receitimes a dayShe did not know why 2 as administered on 06/07 4 times a day and the MA a day administrationShe thought the number date was the number of the training of the trainin	ined on how to complete 16/05/21 was entered 2 were administered. Die dose" on 06/05/21. Die dose were documented 17/21 when it was ordered AR documented 4 times If down the side by the Itablets remaining and did Itation 05/29/21 there could Itation 18/29/21 there could Itation 18/29/21 there were only Itations if there were only Itational medications Ithe pharmacy. Itho ever signed the Itational medications Ithe pharmacy. Ithour 18/20/21 at Itational Itational Itational Italian Itational Itational Italian Itational Itational Italian Itational Italian			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. E.		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		SURVEY PLETED	
		B. WING			R	
		FCL011022			06	3/25/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	1	VELY BRANCH R	OAD		
	T		ER, NC 28732			T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 612	Continued From page	: 43	C 612			
C 612	10A NCAC 13G .170 ² Control Program (tem	1 (c) Infection Prevention & p)	C 612			
	(c) When a communic been identified at the emerging infectious d threat, the facility sha the facility 's IPCP, re procedures, and public guidance issued by the guidance or directives communicable disease emerging infectious d issued in writing by the department, the species	control program cable disease outbreak has facility or there is an isease Il ensure implementation of elated policies and ished he CDC; however, if s specific to the he outbreak or isease threat have been e NCDHHS or local health				
	failed to ensure recon by the Centers for Dis North Carolina Depar Services (NCDHHS) the global Coronaviru related to COVID-19 and residents.	as evidenced by: as and interviews, the facility amendations and guidance sease Control (CDC) and the atment of Health and Human were implemented during s (COVID-19) pandemic as screening of staff, visitors				
	The findings are:					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		'	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		FCL011022	B. WING		R 06/25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
EAID\/IE\A	/ FAMILY CARE HOME #	256 GRAV	ELY BRANCH I	ROAD	
FAIRVIEW	FAMILY CARE HOME #	FLETCHE	R, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLÉTE
C 612	Continued From page	e 44	C 612		
	prevention and spread Disease in long term 03/29/21 revealed: -All essential visitors presence of fever and when entering the butage -A strong infection proprogram is critical to healthcare personnel. Review of the NCDH prevention and spread Disease in LTC facilital -Recommended routing control (IPC) practice pandemic included so healthcare facility for COVID-19.	should be screened for the d symptoms of the virus ilding. evention and control protect both residents and . HS guidelines for the d of the Coronavirus ies dated 05/05/21 revealed: ne infection prevention is during the COVID-19 creening anyone entering a signs and symptoms of set to the date of the coronavirus ies dated 05/05/21 revealed: ne infection prevention is during the COVID-19 creening anyone entering a signs and symptoms of			
	Review of the facility's infection control policy revealed the policy had not been updated since the beginning of the COVID-19 pandemic.				
	surveyors entered the screening or tempera	8/21 at 9:00am revealed two e facility with no COVID-19 htures checks and there were nnaire or thermometer ance 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 holderThere was a hand-held thermometer				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL011022	B. WING		06/2	5/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
FAIRVIEW	FAMILY CARE HOME #	1	ELY BRANCH F	ROAD		
			R, NC 28732			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 612	Continued From page	÷ 45	C 612			
	the dining room table not offer to screen the	•				
	revealed: -Staff did not screen h	ent on 06/18/21 at 11:48am ner for COVID-19 symptoms				
	or take her temperatureThere 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.					
	beginning of the pand checks.	were never asked since the lemic, just temperature were stopped about the accines 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.					
	9:20am revealed: -She screened visitor	ninistrator on 06/23/21 at s to the facility sometimes				
	-She did not understa screen visitors to the -A surveyor asked the	Administrator if she wanted				
	said "no."	ture and the Administrator				
C 912	G.S. 131D-21(2) Dec	laration of Residents' Rights	C 912			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		FCL011022	B. WING		06/25/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FAIRVIEW	FAMILY CARE HOME #	1	LY BRANCH I	ROAD	
	Г	FLETCHER	R, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 912	Continued From page	2 46	C 912		
	Every resident shall h 2. To receive care an adequate, appropriate	ration of Resident's Rights lave the following rights: Id services which are e, and in compliance with state laws and rules and			
	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)].				
	facility failed to ensur- healthcare needs was residents (Resident#	rs and record reviews the e a referral to meet acute s made for 1 of 3 sampled 1) related to a psychology 246, 10A NCAC 13G (Type Unabated A1			
	reviews the facility fai medications as order residents (Residents medication to treat an schizophrenia (Reside	ed for 2 of 3 sampled #1 and #2) related to a			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING:		
		FCL011022	B. WING		R 06/25/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FAIRVIEW	FAMILY CARE HOME #	256 GRAVE	LY BRANCH I	ROAD	
FLETCH			R, NC 28732		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 912	Continued From page	2 47	C 912		
		Refer to Tag 0330, 10A Medication Administration			
C 914	G.S 131D-21(4) Deck	aration Of Resident's Rights	C 914		
		nave the following rights: al and physical abuse, ion.			
	This Rule is not met a Based on observation interviews the facility resident was free of n management and oth	ns, record reviews and failed to ensure each eglect related to			
	The findings are:				
	interviews the Administration management and total were maintained to ended rules and statutes of a each resident's rights appropriate care and neglect as related to the healthcare referral, maintaining a controll and infection preventi	ions, record reviews and strator failed to ensure the all operations of the facility insure compliance with the adult care homes to protect to receive adequate and services and to be free of resident supervision, edication administration, ed substance count sheet on. [Refer to Tag 0185, 10A Management and other staff			

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