PRINTED: 07/09/2021 FORM APPROVED

| Division of              | of Health Service Regu  | lation  |                     |  |                               |
|--------------------------|---|---|---------------------|--|-------------------------------|
|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ' '                 | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|                          |   | FCL011023   | B. WING             |  | R-C<br><b>06/22/2021</b>      |
| NAME OF D                | ROVIDER OR SUPPLIER   | CTDEET A  | DDRESS, CITY, STA   | TE ZIR CODE  |                               |
| NAME OF T                | NOVIDER OR SOLT EIER  |   | VELY BRANCH F       |  |                               |
| FAIRVIEW                 | FAMILY CARE HOME #  | 2   | ER, NC 28732        |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE                   |
| C 000                    | Initial Comments  |   | C 000               |  |                               |
|                          | annual and follow-up  | sure Section conducted an survey on 06/16/21 to 1 with a telephone exit on  |                     |  |                               |
| C 078                    | 10A NCAC 13G .0315<br>Furnishings   | 5(a)(5) Housekeeping and  | C 078               |  |                               |
|                          | 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; |   |                     |  |                               |
|                          | · ·   | to new and existing homes.  |                     |  |                               |
|                          | failed to maintain the<br>free of obstructions a<br>and mildew build-up of<br>shower in the men's of  | as evidenced by:  n and interviews the facility facility in a clean manner,  nd hazards related to mold  on the tile and grout in the common bathroom and a  men's common bathroom. |                     |  |                               |
|                          | The findings are:   |   |                     |  |                               |
|                          | 06/16/21 at 8:40am re<br>-There was a missing<br>-There was a large bu<br>on the tile and grout.  | ceramic tile.<br>uild-up of mold and mildew<br>n the tile and the tub was   |                     |  |                               |
|                          | Interview with the Sup  | pervisor In Charge (SIC) on   |                     |  |                               |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|---|--|---|-------------------------------|--------------------------|
|                          |   |   |  |   | R-C                           |                          |
|                          |   | FCL011023   | B. WING                                  |   | 06/22/2                       | 021                      |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET ADD  | DRESS, CITY, STA                         | TE, ZIP CODE  |                               |                          |
| FAIRVIEW                 | FAMILY CARE HOME #  | 2   | ELY BRANCH F                             | ROAD  |                               |                          |
|                          | Г   | FLETCHE   | R, NC 28732                              |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE C                          | (X5)<br>COMPLETE<br>DATE |
| C 078                    | Continued From page   | e 1   | C 078                                    |   |                               |                          |
|                          | dailyShe knew the tile and shower in the men's of build-up of mold and -She had done every and had not been such Interview with the Adr 12:15pm revealed: -She did not know the common bathroom had   | e for cleaning the bathrooms  d grout surrounding the common bathroom had a mildew. thing she could to clean it ccessful.  ministrator on 06/17/21 at e shower in the men's |  |   |                               |                          |
|                          | <ul> <li>2. Observation of the women's common bathroom on 06/16/21 at 9:06am revealed: -There was a piece of plywood on the floor in front of the commodeThe floor under the plywood was soft and flexibleA piece of flooring approximately 4 inches by 8 inches was missing and the surrounding flooring was crackedThe subfloor exposed under the missing flooring was rotten.</li> </ul> |   |  |   |                               |                          |
|                          | O6/17/21 at 8:59am re -The floor in front of the common bathroom we she noticed it a weet plywood over the rotting repairedA family member was soon as she obtained.  | he commode in the women's as rotting. k ago and put a piece of ing spot until it could be s going to repair the floor as  |  |   |                               |                          |

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revealed:

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  |   | (X2) MULTIPLE C                 |  |                              | E SURVEY<br>PLETED       |
|--|--|---|---------------------------------|--|------------------------------|--------------------------|
|  |  | FCL011023   | B. WING                         |  |                              | R-C<br>6/ <b>22/2021</b> |
| NAME OF P  | ROVIDER OR SUPPLIER  | STREET A  | DDRESS, CITY, STATE             | , ZIP CODE   |                              |                          |
| FAIRVIEW   | / FAMILY CARE HOME #   | 2   | AVELY BRANCH RO<br>ER, NC 28732 | PAD  |                              |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG             | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| C 078  | -The floor in the wom rotting in front of the control of the contr | en's common bathroom was commode. Ind put a piece of plywood a few days ago". Ind put a piece of plywood a few days ago". Ind put a piece of plywood a few days ago". Ind put a piece of plywood a few days ago". Ind put a piece of plywood a few days ago". Ind put a piece of plywood ago affect was a few days ago". Ind put a piece of plywood ago affect affect was ago affect ago affect ago ago affect ago affect ago ago ago affect ago ago ago affect ago | C 078                           |  |                              |                          |
| C 202  | Medical Examination  10A NCAC 13G .0702  Medical Examination (a) Upon admission resident shall be tester   | 2(a) Tuberculosis Test and  2 Tuberculosis Test and  to a family care home each ed for tuberculosis disease e control measures adopted  | C 202                           |  |                              |                          |
|  | by the Commission for specified in 10A NCA   | •   |                                 |  |                              |                          |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  |                     |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|---------------------|--|-------------------------------|--------------------------|
|   |   |   | A. BUILDING:        | A. BUILDING:   |                               |                          |
|   |   | FCL011023   | B. WING             |  | l l                           | R-C<br>5/ <b>22/2021</b> |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, STATE  | E, ZIP CODE  |                               |                          |
| EAID\/IE\A  | / FAMILY CARE HOME #  | 256 GRAN  | ELY BRANCH RO       | DAD  |                               |                          |
| FAIRVIEW  | / FAMILY CARE HOME #  | FLETCHE   | R, NC 28732         |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | N SHOULD BE<br>E APPROPRIATE  | (X5)<br>COMPLETE<br>DATE |
| C 202   | Continued From page   | · 3   | C 202               |  |                               |                          |
| 0 202   | the rule are available<br>the Department of He<br>Tuberculosis Control  | at no charge by contacting alth and Human Services, Program, 1902 Mail Service h Carolina 27699-1902.   | 0 202               |  |                               |                          |
|   | facility failed to ensur  | as evidenced by:<br>ews and interviews, the<br>e 1 of 3 sampled residents<br>sted for Tuberculosis (TB)   |                     |  |                               |                          |
|   | The findings are:   |   |                     |  |                               |                          |
|   | Review of Resident #<br>10/19/20 revealed dia<br>failure and iliac artery   | ignoses included renal  |                     |  |                               |                          |
|   | test that aids in the do<br>TB and is an alternati<br>started on 07/13/18 a<br>-The Quantiferon-TB<br>stopped on 07/17/18<br>-There were no docu<br>#1's Quantiferon-TB 0<br>-There were no other | eron-TB Gold test (a blood<br>etection of Mycobacterium<br>ve to tuberculin skin tests)<br>t 2:27pm.<br>Gold blood test was<br>at 3:08pm.<br>mented results of Resident |                     |  |                               |                          |
|   | on 06/16/21 at 3:20pr<br>lived at an independe<br>admitted to the sister  | ved to her building on  |                     |  |                               |                          |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|--|---------------------|---|-------------------------------|--|
|   |   |  | 7 50.12510.         |   | R-C                           |  |
|   |   | FCL011023  | B. WING             |   | 06/22/2021                    |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD   | DRESS, CITY, STA    | TE, ZIP CODE  |                               |  |
| FAIRVIEW  | FAMILY CARE HOME #  | 256 GRAV   | ELY BRANCH I        | ROAD  |                               |  |
| .,  |   | FLETCHER   | R, NC 28732         |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE                   |  |
| C 202   | Continued From page   | e 4  | C 202               |   |                               |  |
|   | did not have to have a Quantiferon-TB Gol -She was responsible completed for resider facility.  | to ensure TB testing was<br>its prior to admission to the  |                     |   |                               |  |
|   | Interview with the Administrator on 06/17/21 at 12:05pm revealed:  -An initial TB test should have been completed for Resident #1 within 30 days of admissionIt was the facility's policy to obtain TB testing within 30 days of admissionIt was difficult to schedule a nurse to place a TB skin testA nurse reviewed the resident records "every 3 months" and the missing TB test information should have been brought to the staff's attentionIt was the SIC's responsibility to ensure TB testing was completed. |  |                     |   |                               |  |
| C 204   | And Medical Examina   |  | C 204               |   |                               |  |
|   | Medical Examination   | 2 Tuberculosis Test And  |                     |   |                               |  |
|   | to be entered on the I Medicaid Program Lo MR-2, North Carolina Retardation Services, following: (1) The examining da MR-2 shall be no mor person's admission to This Rule is not met   | Ing Term Care Services, or Medicaid Program Mental which shall comply with the te recorded on the FL-2 or the than 90 days prior to the to the home. |                     |   |                               |  |

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Division of Health Service Regulation

| DIVISION          | or riealin Service Negu   | lation                         |                 |                                 |             |                  |
|-------------------|---------------------------|--------------------------------|-----------------|---------------------------------|-------------|------------------|
| STATEMENT         | FOF DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA    | (X2) MULTIPLE   | CONSTRUCTION                    | (X3) DATE S | URVEY            |
| AND PLAN (        | OF CORRECTION             | IDENTIFICATION NUMBER:         | A. BUILDING:    |                                 | COMPL       | ETED             |
|                   |                           |                                | _               |                                 |             |                  |
|                   |                           |                                |                 |                                 | R-          | C                |
|                   |                           | FCL011023                      | B. WING         |                                 | 06/2        | 2/2021           |
|                   |                           |                                |                 |                                 |             |                  |
| NAME OF P         | ROVIDER OR SUPPLIER       | STREET ADD                     | RESS, CITY, STA | TE, ZIP CODE                    |             |                  |
| EAID\/IE\A        | FAMILY CARE HOME #        | 256 GRAV                       | ELY BRANCH I    | ROAD                            |             |                  |
| FAIRVIEW          | FAMILY CARE HOME #        | FLETCHEF                       | R, NC 28732     |                                 |             |                  |
| 0/1/15            | STIMMADV ST               | ATEMENT OF DEFICIENCIES        | <u> </u>        | PROVIDER'S PLAN OF CORRECTION   | 1           | 0(5)             |
| (X4) ID<br>PREFIX |                           | Y MUST BE PRECEDED BY FULL     | ID<br>PREFIX    | (EACH CORRECTIVE ACTION SHOULD  |             | (X5)<br>COMPLETE |
| TAG               |                           | SC IDENTIFYING INFORMATION)    | TAG             | CROSS-REFERENCED TO THE APPROPR |             | DATE             |
|                   |                           |                                |                 | DEFICIENCY)                     |             |                  |
|                   |                           |                                |                 |                                 |             |                  |
| C 204             | Continued From page       | e 5                            | C 204           |                                 |             |                  |
|                   | facility failed to analys | a the evenining date           |                 |                                 |             |                  |
|                   | facility failed to ensure | •                              |                 |                                 |             |                  |
|                   |                           | was no more than 90 days       |                 |                                 |             |                  |
|                   |                           | 1 of 3 sampled residents       |                 |                                 |             |                  |
|                   | (Resident #1).            |                                |                 |                                 |             |                  |
|                   |                           |                                |                 |                                 |             |                  |
|                   | The findings are:         |                                |                 |                                 |             |                  |
|                   |                           |                                |                 |                                 |             |                  |
|                   | Review of Resident #      | 1's FL2 dated 03/05/20         |                 |                                 |             |                  |
|                   | revealed:                 |                                |                 |                                 |             |                  |
|                   |                           | cognitive changes due to       |                 |                                 |             |                  |
|                   | _                         | •                              |                 |                                 |             |                  |
|                   |                           | primary, atrial fibrillation,  |                 |                                 |             |                  |
|                   |                           | ertension, anoxic brain        |                 |                                 |             |                  |
|                   |                           | , and hypercholesterolemia.    |                 |                                 |             |                  |
|                   | -The resident was am      | bulatory and continent of      |                 |                                 |             |                  |
|                   | bladder and bowel.        |                                |                 |                                 |             |                  |
|                   |                           |                                |                 |                                 |             |                  |
|                   | Review of Resident #      | 1's current FL2 dated          |                 |                                 |             |                  |
|                   | 10/19/20 revealed dia     | agnoses included renal         |                 |                                 |             |                  |
|                   | failure and iliac artery  | •                              |                 |                                 |             |                  |
|                   | landro arra mao artory    | ansaryon.                      |                 |                                 |             |                  |
|                   | Review of Resident #      | 1's record revealed there      |                 |                                 |             |                  |
|                   | ***                       |                                |                 |                                 |             |                  |
|                   |                           | ation of the resident's orders |                 |                                 |             |                  |
|                   |                           | Provider (PCP) within 90       |                 |                                 |             |                  |
|                   | days of the resident a    | idmission.                     |                 |                                 |             |                  |
|                   |                           |                                |                 |                                 |             |                  |
|                   |                           | pervisor-In-Charge (SIC) on    |                 |                                 |             |                  |
|                   | 06/16/21 at 1:10pm re     | evealed:                       |                 |                                 |             |                  |
|                   | -Resident #1 had mov      | ved to her building on         |                 |                                 |             |                  |
|                   | 03/26/21 or 03/27/21      | <u> </u>                       |                 |                                 |             |                  |
|                   |                           | ter facility had told her the  |                 |                                 |             |                  |
|                   |                           | the resident record was the    |                 |                                 |             |                  |
|                   | current FL2.              | Tallo resident resorta was the |                 |                                 |             |                  |
|                   |                           | tor facility had tald be-      |                 |                                 |             |                  |
|                   |                           | ter facility had told her      |                 |                                 |             |                  |
|                   | **                        | n taken to the doctor in       |                 |                                 |             |                  |
|                   | February 2021 for a for   |                                |                 |                                 |             |                  |
|                   | -She noticed the date     | on the FL2 was 02/11/20,       |                 |                                 |             |                  |
|                   | but she was told by th    | ne previous SIC the year on    |                 |                                 |             |                  |
|                   | the FL2 was suppose       |                                |                 |                                 |             |                  |
|                   |                           | ility to obtain a new FL2 on   |                 |                                 |             |                  |
|                   | -it was not responsible   | mry to obtain a new I LZ On    | 1               |                                 |             |                  |

Division of Health Service Regulation

admission if the FL2 was over 90 days old.

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| STATEMENT                | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                             | ` '                 | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|--|---------------------|--|-------------------------------|--------------------------|
|                          |  |  |                     |  | R-                            | С                        |
|                          |  | FCL011023  | B. WING             |  | 06/2                          | 2/2021                   |
| NAME OF PI               | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE   |                               |                          |
| FAIRVIEW                 | FAMILY CARE HOME #   | 2  | ELY BRANCH F        | ROAD   |                               |                          |
|                          | OLIMAN DV OT   |  | R, NC 28732         | DDOWNERIO DI ANI OF CORRECTION   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| C 204                    | Continued From page  | <del>2</del> 6   | C 204               |  |                               |                          |
|                          | -She did not get a new FL2 for Resident #1 upon admissionShe did not clarify any of Resident #1's orders upon admission.   |  |                     |  |                               |                          |
|                          | Interview with the Administrator on 06/17/21 at 12:05pm revealed:  -The SIC should have obtained another FL2 for Resident #1 upon admission if the FL2 had been completed over 90 days.  -The SIC had been trained to obtain a new FL2 upon admission.  -The SIC was responsible to ensure all admission orders were received from the PCP.  |  |                     |  |                               |                          |
| C 242                    | 2:12pm was unsucce   |  | C 242               |  |                               |                          |
|                          | C 242  10A NCAC 13G .0901(a) Personal Care and Supervision  10A NCAC 13G .0901 Personal Care and Supervision  (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.  This Rule is not met as evidenced by: TYPE A2 VIOLATION  Based on observations, interviews and record reviews, the facility failed to ensure personal care was provided for 1 of 3 sampled residents (#1) as related to bathing, mouth care, toenail care, and shaving. |  |                     |  |                               |                          |

Division of Health Service Regulation

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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<br>COMPLETED   |                          |
|---|--|---|---------------------|---|--------------------------|
|   |  |   | A. BUILDING         |   |                          |
|   |  | FCL011023   | B. WING             |   | R-C<br><b>06/22/2021</b> |
| NAME OF PI  | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                          |
| FAIRVIEW  | FAMILY CARE HOME #   | 256 GRAVI   | ELY BRANCH I        | ROAD  |                          |
| TAIRVIEV  | TAMILI GARLITOME   | FLETCHEF  | R, NC 28732         |   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>.SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE              |
| C 242   | Continued From page  | e 7   | C 242               |   |                          |
|   | The findings are:  |   |                     |   |                          |
|   | Review of Resident #<br>10/19/20 revealed dia<br>failure and iliac artery  | agnoses included renal  |                     |   |                          |
|   | and bathing.   | d supervision with eating   |                     |   |                          |
|   | Observation of Reside 8:42am revealed: -The resident had a sperspirationThe resident was noted to a sperspirationThe great toenail on yellowed, thickened, sprotruded approximate his toeThe second toenail of yellowed, thickened, sprotruded approximate his toeThe great toenail on yellowed, thickened, sprotruded approximate special of yellowed, thickened, sprotruded, sprotruded, thickened, sprotruded, sp | ent #1 on 06/16/21 at  trong body odor of  t wearing shoes or socks. the resident's left foot was had an uneven edge, and tely 1/2 inch past the flesh of on the resident's left foot was had an uneven edge, and tely 1/2 inch past the flesh of the resident's right foot was and protruded approximately of his toe. on the resident's right foot hed, and protruded th past the flesh of his toe. was thick and th long on his face and neck. |                     |   |                          |
|   | 06/16/21 at 1:10pm removed to the facility of  | pervisor-In-Charge (SIC) on<br>evealed Resident #1 had<br>on 03/26/21 or 03/27/21.<br>on #1 on 06/16/21 at 8:42am   |                     |   |                          |

Division of Health Service Regulation

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| DIVISION   | n nealth Service Regu    | iation                                |                  |  |                  |
|------------|--------------------------|---------------------------------------|------------------|--|------------------|
| STATEMENT  | OF DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA           | (X2) MULTIPLE    | CONSTRUCTION   | (X3) DATE SURVEY |
| AND PLAN ( | OF CORRECTION            | IDENTIFICATION NUMBER:                | A. BUILDING:     |  | COMPLETED        |
|            |                          |                                       |                  | <del></del>  |                  |
|            |                          |                                       |                  |  | R-C              |
|            |                          | FCL011023                             | B. WING          | <del></del>  | 06/22/2021       |
|            |                          |                                       | - I              |  |                  |
| NAME OF P  | ROVIDER OR SUPPLIER      | STREET ADD                            | DRESS, CITY, STA | TE, ZIP CODE   |                  |
|            |                          | 256 GRAV                              | ELY BRANCH I     | ROAD   |                  |
| FAIRVIEW   | FAMILY CARE HOME #       | 2 FLETCHE                             | R, NC 28732      |  |                  |
|            |                          | TELIONE                               | 1, 110 20732     |  |                  |
| (X4) ID    |                          | ATEMENT OF DEFICIENCIES               | ID               | PROVIDER'S PLAN OF CORRECTION                                  | ( - /            |
| PREFIX     |                          | Y MUST BE PRECEDED BY FULL            | PREFIX           | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR |                  |
| TAG        | REGULATORT OR L          | LSC IDENTIFYING INFORMATION)          | TAG              | DEFICIENCY)  | NATE DATE        |
|            |                          |                                       |                  | BETTOLENOTY  |                  |
| C 242      | Continued From page      | , Q                                   | C 242            |  |                  |
| 0 242      | Continued i Tom page     | 5 0                                   | 0242             |  |                  |
|            | revealed:                |                                       |                  |  |                  |
|            | -He needed assistance    | ce with cutting his toenails.         |                  |  |                  |
|            |                          | embered his toenails being            |                  |  |                  |
|            |                          |                                       |                  |  |                  |
|            | trimmed was "six mor     | •                                     |                  |  |                  |
|            |                          | and received was when he              |                  |  |                  |
|            | lived "in the other buil |                                       |                  |  |                  |
|            | -He had not received     | a shower since he moved to            |                  |  |                  |
|            | the new facility.        |                                       |                  |  |                  |
|            |                          | his bed linens had not been           |                  |  |                  |
|            | washed since he mov      |                                       |                  |  |                  |
|            | Wachea chico no mov      | ou to the lability.                   |                  |  |                  |
|            | Interview with Reside    | nt #1 on 06/17/21 at                  |                  |  |                  |
|            |                          | 111 #1 011 00/17/21 at                |                  |  |                  |
|            | 11:18am revealed:        |                                       |                  |  |                  |
|            |                          | ber the last time his dirty           |                  |  |                  |
|            | clothes were washed.     |                                       |                  |  |                  |
|            | -Staff had not offered   | to wash his clothes since             |                  |  |                  |
|            | he had been in the fa    | cility.                               |                  |  |                  |
|            | -He had not received     | a shower since he came to             |                  |  |                  |
|            | live in the new facility |                                       |                  |  |                  |
|            | _                        | ponge bath nor had staff              |                  |  |                  |
|            | offered him a sponge     | · -                                   |                  |  |                  |
|            | . •                      | ber the last time he brushed          |                  |  |                  |
|            |                          | bei tile last tillle lie blusiled     |                  |  |                  |
|            | his teeth.               |                                       |                  |  |                  |
|            |                          | ber the last time he had              |                  |  |                  |
|            | been shaved.             |                                       |                  |  |                  |
|            | -He liked to be clean    |                                       |                  |  |                  |
|            | -He did not like the le  | ngth of his beard and he              |                  |  |                  |
|            | "hated" having a mus     | tache.                                |                  |  |                  |
|            | -The staff had never of  | offered to trim his hair,             |                  |  |                  |
|            | mustache, and beard      | · · · · · · · · · · · · · · · · · · · |                  |  |                  |
|            | -The staff had never of  |                                       |                  |  |                  |
|            | -His hair was long on    |                                       |                  |  |                  |
|            |                          | had in the past arranged for          |                  |  |                  |
|            |                          |                                       |                  |  |                  |
|            | haircuts and facial ha   |                                       |                  |  |                  |
|            | -He saw his Guardian     | i "two times a month."                |                  |  |                  |
|            |                          |                                       |                  |  |                  |
|            |                          | othes hamper in the corner            |                  |  |                  |
|            | of Resident #1's room    | n on 06/17/21 at 11:42am              |                  |  |                  |
|            | revealed:                |                                       |                  |  |                  |

Division of Health Service Regulation

-The hamper was full of dirty clothes.

STATE FORM 6899 NM2Z11 If continuation sheet 9 of 44

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  |                             | (X3) DATE SURVEY<br>COMPLETED  |   |
|---|---|---|-----------------------------|--|---|
| AND PLAN  | OF CORRECTION                                   | IDENTIFICATION NOWBER.  | A. BUILDING: _              |  | COMPLETED                               |
|   |   | FCL011023   | B. WING                     |  | R-C<br><b>06/22/2021</b>                |
| NAME OF D   | ROVIDER OR SUPPLIER                             | etpeet ADI  | DRESS, CITY, STA            | TE ZID CODE  | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| NAME OF P   | ROVIDER OR SUPPLIER                             |   | ELY BRANCH I                |  |   |
| FAIRVIEW  | FAMILY CARE HOME #                              | 2   | ELT BRANCH I<br>R, NC 28732 | ROAD   |   |
| 0/0.15  | SLIMMADV ST                                     |   | 1                           | DBO//IDED'S DI AN CE CORRECTIO   | NI (VE)                                 |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC                                 | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETE                           |
| C 242   | Continued From page                             | 9   | C 242                       |  |   |
|   |   |   |                             |  |   |
|   | front of the hamper of                          | ile of dirty clothes lying in<br>n the floor.                                   |                             |  |   |
|   | Observation of the be                           | edside table in Resident #1's   |                             |  |   |
|   |   | cup on the bedside table top.   |                             |  |   |
|   |   | othbrushes and one tube of  |                             |  |   |
|   | toothpaste available i                          | n the plastic cup.  |                             |  |   |
|   | Telephone interview v                           | with Resident #1's Guardian   |                             |  |   |
|   | on 06/17/21 at 3:20pr                           |   |                             |  |   |
|   |   | ard" to get into the shower.  |                             |  |   |
|   |   | stable on his feet and so he  |                             |  |   |
|   | was "afraid" he might                           | ous facility would stand at   |                             |  |   |
|   |   | keep an eye on him" as he   |                             |  |   |
|   | showered.                                       | receptant eye on min as ne  |                             |  |   |
|   |   | t able to do his own toenail  |                             |  |   |
|   | care.   |   |                             |  |   |
|   |   | en "seeing a podiatrist" at   |                             |  |   |
|   | his local health care p                         |   |                             |  |   |
|   | -Facility staff provided                        | d transport to appointments.  |                             |  |   |
|   | Interview with the Sup<br>06/16/21 at 1:10pm re | pervisor-In-Charge (SIC) on   |                             |  |   |
|   |   | a new admission, it was her   |                             |  |   |
|   |   | k the care plan and provide   |                             |  |   |
|   | -She tried to get Resi                          | dent #1 to take a bath since  |                             |  |   |
|   | he was admitted.                                | t him to take a sponge bath.  |                             |  |   |
|   |   | she was unable to get him   |                             |  |   |
|   | to bathe or take a spo                          |   |                             |  |   |
|   |   | Guardian about him not  |                             |  |   |
|   |   | dian replied "that's just how   |                             |  |   |
|   |   | eek for staff in the previous   |                             |  |   |
|   | sister facility where he                        | e lived.  |                             |  |   |
|   |   | ne refused because it was a   |                             |  |   |
|   | new environment or b                            | pecause he just did not want  |                             |  |   |

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 10 of 44

| Division of   | of Health Service Regu  | lation   |                  |  |             |                  |
|---------------|---|--|------------------|--|-------------|------------------|
|               | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE    | CONSTRUCTION   | (X3) DATE S |                  |
| AND PLAN C    | OF CORRECTION   | IDENTIFICATION NUMBER:                                     | A. BUILDING: _   |  | COMPLE      | ≣TED             |
|               |   |  |                  |  | l R-        | C                |
|               |   | FCL011023  | B. WING          |  | 1           | 2/2021           |
|               |   |  |                  |  |             |                  |
| NAME OF PR    | ROVIDER OR SUPPLIER   |  | DRESS, CITY, STA |  |             |                  |
| FAIRVIEW      | FAMILY CARE HOME #  | 2  | ELY BRANCH F     | ROAD   |             |                  |
|               |   | FLETCHE  | R, NC 28732      |  |             |                  |
| (X4) ID       |   | ATEMENT OF DEFICIENCIES                                    | ID               | PROVIDER'S PLAN OF CORRECTIO                                   |             | (X5)             |
| PREFIX<br>TAG |   | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX<br>TAG    | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI |             | COMPLETE<br>DATE |
|               | 1   |  |                  | DEFICIENCY)  |             |                  |
| C 242         | O   | -10  | C 242            |  |             |                  |
| C 242         | Continued From page   | <del>3</del> 10  | C 242            |  |             |                  |
|               | to take a bath.   |  | 1                |  |             | i                |
|               |   | d him for his dirty laundry,                               | 1                |  |             |                  |
|               | the resident would tel  | ll her he did not have any                                 |                  |  |             |                  |
|               | dirty laundry.  |  |                  |  |             |                  |
|               | _   | m and look around without                                  |                  |  |             | ,                |
|               | his permission."  |  |                  |  |             | ,                |
|               | •   | et Resident #1 to cut his                                  |                  |  |             | ,                |
|               | toenails.   | Desident HAIs to smalle                                    |                  |  |             | ,                |
|               | -She did not know who were last trimmed.  | nen Resident #1's toenails                                 |                  |  |             | ,                |
|               | -The length of Reside   | ent #1's toonsils were                                     |                  |  |             | ,                |
|               | "ridiculous."   | III # I S LUCIIAIIS WEIG                                   |                  |  |             | ı                |
|               |   | er Resident #1 was afraid of                               | 1                |  |             | ı                |
|               | falling.  | 1 Nosidone ii 1 was anala si                               | 1                |  |             | ı                |
|               | •   | t she would sit with him while                             | 1                |  |             | ı                |
|               | he was showering.   |  | 1                |  |             | ı                |
|               | -She told him his toer  | nails would be easier to cut                               | 1                |  |             | ı                |
|               | after a shower.   |  | 1                |  |             | ı                |
|               |   | ell her he would take a                                    | 1                |  |             | ı                |
|               | shower "but he just w   |  |                  |  |             | ,                |
|               |   | ils "were so long now" she                                 |                  |  |             | ,                |
|               | was afraid to cut then  |  |                  |  |             | ,                |
|               | -She thought he need  | led to be seen by a  | 1                |  |             | i                |
|               | podiatristShe was not sure if F   | Resident #1's local health                                 | 1                |  |             | ı                |
|               |   | podiatry services or not.                                  | 1                |  |             | ı                |
|               | odio piovido, olio. 11  | podiatry convious strate.                                  | 1                |  |             | ı                |
|               | Interview with the pre  | evious SIC from the sister                                 | 1                |  |             | ı                |
|               | facility on 06/16/21 at   |  | 1                |  |             | i                |
|               | -Resident #1 cut his o  |  | 1                |  |             | ı                |
|               | -"Maybe" his Guardia  | in would come to the facility                              |                  |  |             |                  |
|               | and cut the resident's  |  |                  |  |             |                  |
|               | o de la companya de | the resident to take a bath                                |                  |  |             |                  |
|               | once a week when he   |  |                  |  |             |                  |
|               |   | unable to get Resident #1                                  |                  |  |             |                  |
|               | to take a bath since h  | ie moved.  |                  |  |             |                  |
|               |   | D == 00/47/04 =+ 44-55===                                  |                  |  |             |                  |
|               | interview with the Sic  | C on 06/17/21 at 11:55am                                   |                  |  |             |                  |

revealed:

-It was her understanding, Resident #1 cared for

STATE FORM 6899 NM2Z11 If continuation sheet 11 of 44

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|---|---|-------------------------------|--------------------------|
|   |  |  | D WING                                  | P. WING   |                               | С                        |
|   |  | FCL011023  | B. WING                                 |   | 06/2                          | 2/2021                   |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STA                        | TE, ZIP CODE  |                               |                          |
| EVID//IE/V  | / FAMILY CARE HOME #   | 256 GRAV   | ELY BRANCH I                            | ROAD  |                               |                          |
| IAIIVILV  | TAMIET OAKE HOME#  | FLETCHE  | R, NC 28732                             |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| C 242   | Continued From page  | e 11   | C 242                                   |   |                               |                          |
| C 242   | his own beardShe did not "even krown teeth"That's how little" she-She saw the resident and the resident took himself off." -She agreed the resident gersonal care as he waccording to his care -Resident #1 needed -Resident #1 needed clothes"He has to trust me elected she noticed Resident #1's toenails.  Interview with the Add 12:15pm revealed: -If a resident was not to tell the resident the showerShe expected staff to cloth and towel and towait right outside the needed"If that did not work, bath." -She expected staff to brush his teethIf the resident would would expect staff to mouthwash to useIf a resident was unathey were not diabetic | a knew about the resident. It go in the bathroom "twice" a washcloth to "wash dent had not been getting was supposed to get plan.  a shower and a shave. It olet her wash his dirty denough to let me do it."  Con 06/17/21 at 2:05pm the length and condition of so "three weeks ago."  ministrator on 06/17/21 at destrict the resident a wash delt the resident they would bathroom to assist if  I would give them a sponge of prompt the resident to not brush his teeth, she offer the resident and condition the shell to cut their toenails and condition the shell the shell to cut their toenails and condition the shell the sh | C 242                                   |   |                               |                          |
|   | -If the resident would would expect staff to mouthwash to useIf a resident was una they were not diabetic the resident's toenails  | offer the resident able to cut their toenails and c, she expected staff to cut   |   |   |                               |                          |

Division of Health Service Regulation

staff to arrange for a visit to podiatry.

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE C   |   |  | E SURVEY<br>PLETED            |                          |
|---|---|---|---|--|-------------------------------|--------------------------|
|   |   | FCL011023   | B. WING   |  | l l                           | R-C<br>5 <b>/22/2021</b> |
|   | ROVIDER OR SUPPLIER FAMILY CARE HOME #  | 256 GRA   | DDRESS, CITY, STATE  VELY BRANCH RO  ER, NC 28732 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                               | PROVIDER'S PLAN OF C<br>(EACH CORRECTIVE ACTIC<br>CROSS-REFERENCED TO TH<br>DEFICIENCY | ON SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| C 242   | wanted to be shavedThey had electric raze to trim facial hairOne of the SIC's in a trim male resident's h arrange an appointme "salon right down the  The failure of the faci with the assistance he mouth care, toenail ca three months let the r odor, wearing dirty cle appearance related to failure placed the resi serious neglect and p constitutes a Type A2  The facility provided a accordance with G.S.  CORRECTION DATE | o shave residents who cors to shave residents and a sister facility would often air, otherwise staff should ent for the resident at a road" from the facility.  Lity to provide Resident #1 required with bathing, are, and shaving for almost resident have a strong body othes and hating his or his unshaven face. This ident at substantial risk for only sical harm and a Violation. | C 242   |  |                               |                          |
| C 246   | to meet the routine ar<br>of residents.  This Rule is not met<br>Based on observation<br>reviews, the facility fa<br>care provider (PCP) v  | 2 Health Care assure referral and follow-up and acute health care needs as evidenced by: as, interviews, and record illed to ensure the primary   | C 246   |  |                               |                          |

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 13 of 44

| e Regulation  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE (        |  |  |  |
|---|------------------------|--|--|--|
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |                        | CONSTRUCTION   | (X3) DATE<br>COMP  | SURVEY<br>LETED  |
| FCL011023   | B. WING                |  |  | R-C<br><b>22/2021</b>  |
| IER STREE   | T ADDRESS, CITY, STATI | E, ZIP CODE  |  |  |
| 256 0   |                        |  |  |  |
| OME # 2 FLET  | CHER, NC 28732         |  |  |  |
| FICIENCY MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG    | (EACH CORRECTIVE ACTION  | SHOULD BE  | (X5)<br>COMPLETE<br>DATE   |
| m page 13   | C 246                  |  |  |  |
| nd shaving since admission and<br>e doses of medications used to<br>llation, high blood pressure,<br>clots, and wheezing and shortness  |                        |  |  |  |
| re:   |                        |  |  |  |
| aled diagnoses included renal   |                        |  |  |  |
| equired supervision with eating required extensive assistance with  |                        |  |  |  |
| ed: nad a strong body odor of was not wearing shoes or socks. nail on the resident's left foot was ened, had an uneven edge, and roximately 1/2 inch past the flesh of penail on the resident's left foot was ened, had an uneven edge, and roximately 1/2 inch past the flesh of mail on the resident's right foot was ened, and protruded approximately ne flesh of his toe. penail on the resident's right foot thickened, and protruded 1/8 inch past the flesh of his toe. |                        |  |  |  |
| H INEO ID MINING ME SEO SEON OF ONLY VEKNOCKON SEKHOO, VE   | LIER STREE  HOME # 2   | ADME #2  IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION)  IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION)  ID PREFIX TAG  ID PREFIX TAG ID PREFIX TAG  ID PREFIX TAG  ID PREFIX TAG  ID PREFIX TAG  ID PREFIX TAG  ID PREFIX TAG | LIER STREET ADDRESS, CITY, STATE, ZIP CODE  256 GRAVELY BRANCH ROAD FLETCHER, NC 28732  MARY STATEMENT OF DEFICIENCIES EFFICIENCY MUST BE PRECEDED BY FULL ORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)  ID PREFIX TAG  PREFIX TAG  C 246  C 246 | LIER STREET ADDRESS, CITY, STATE, ZIP CODE  256 GRAVELY BRANCH ROAD  FLETCHER, NC 28732  MARY STATEMENT OF DEPTICENCIES FRICIENCY MUST BE PRECEDED BY PILL OWN OR LSC IDENTIFYING INFORMATION)  OWN DRIES OF THE PRECEDED BY PILL OWN OR LSC IDENTIFYING INFORMATION)  OWN DRIES OF THE PRECEDED BY PILL OWN OR LSC IDENTIFYING INFORMATION)  OWN DRIES OF THE PRECEDED BY PILL OWN DRIES OF THE PRECEDED BY PILL OWN OR LSC IDENTIFYING INFORMATION)  OWN DRIES OF THE PRECEDED BY PILL OWN OR LSC IDENTIFYING INFORMATION)  OWN DRIES OF THE PRECEDED BY PILL OWN DRIES OF THE PRECEDED BY PILL OWN OR SERVICE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY  OWN DRIES OF THE PRECEDED BY PILL OWN DRIES OF THE PRECEDED BY THE PRECEDED |

STATE FORM 6899 NM2Z11 If continuation sheet 14 of 44

| Division of Health Service Regulation |   |                                      |                  |                                 |             |                  |
|---------------------------------------|---|--------------------------------------|------------------|---------------------------------|-------------|------------------|
| STATEMENT                             | OF DEFICIENCIES                             | (X1) PROVIDER/SUPPLIER/CLIA          | (X2) MULTIPLE    | CONSTRUCTION                    | (X3) DATE S | URVEY            |
| AND PLAN (                            | OF CORRECTION                               | IDENTIFICATION NUMBER:               | A. BUILDING:     |                                 | COMPLI      | ETED             |
|                                       |   |                                      | _                |                                 |             | _                |
|                                       |   |                                      | B. WING          |                                 | R-          |                  |
|                                       |   | FCL011023                            | B. W(0           |                                 | 06/2        | 2/2021           |
| NAME OF PI                            | ROVIDER OR SUPPLIER                         | STREET AD                            | DRESS, CITY, STA | TE, ZIP CODE                    |             |                  |
|                                       |   | 256 GRAV                             | ELY BRANCH       | ROAD                            |             |                  |
| FAIRVIEW                              | FAMILY CARE HOME #                          | 2 FLETCHE                            | R, NC 28732      |                                 |             |                  |
| (V4) ID                               | SLIMMARY ST                                 | ATEMENT OF DEFICIENCIES              |                  | PROVIDER'S PLAN OF CORRECTION   | N           | (VE)             |
| (X4) ID<br>PREFIX                     |   | Y MUST BE PRECEDED BY FULL           | ID<br>PREFIX     | (EACH CORRECTIVE ACTION SHOULD  |             | (X5)<br>COMPLETE |
| TAG                                   | REGULATORY OR I                             | LSC IDENTIFYING INFORMATION)         | TAG              | CROSS-REFERENCED TO THE APPROPE | RIATE       | DATE             |
|                                       |   |                                      |                  | DEFICIENCY)                     |             |                  |
| C 246                                 | Continued From page                         | e 14                                 | C 246            |                                 |             | I                |
|                                       |   |                                      |                  |                                 |             | 1                |
|                                       |   |                                      |                  |                                 |             | 1                |
|                                       |   | ent #1 on 06/16/21 at 8:42am         |                  |                                 |             | 1                |
|                                       | revealed:                                   |                                      |                  |                                 |             | 1                |
|                                       |   | ce with cutting his toenails.        |                  |                                 |             | 1                |
|                                       |   | embered his toenails being           |                  |                                 |             | 1                |
|                                       | trimmed was "six mor                        | •                                    |                  |                                 |             | 1                |
|                                       |   | nad received was when he             |                  |                                 |             | 1                |
|                                       | lived "in the other buil                    | •                                    |                  |                                 |             | 1                |
|                                       |   | a shower since he moved to           |                  |                                 |             | 1                |
|                                       | the new facility.                           | his had linear had not have          |                  |                                 |             | 1                |
|                                       |   | his bed linens had not been          |                  |                                 |             | I                |
|                                       | washed since he mov                         | ved to the facility.                 |                  |                                 |             | I                |
|                                       | Interview with Reside                       | ent #1 on 06/17/21 at                |                  |                                 |             | I                |
|                                       | 11:18am revealed:                           | ,                                    |                  |                                 |             | 1                |
|                                       | -He had not received                        | a shower since he came to            |                  |                                 |             | I                |
|                                       | live in the new facility                    | · .                                  |                  |                                 |             | I                |
|                                       | -He had not taken a s                       | sponge bath nor had staff            |                  |                                 |             | I                |
|                                       | offered him a sponge                        |                                      |                  |                                 |             | I                |
|                                       | -He could not remem                         | ber the last time he brushed         |                  |                                 |             | 1                |
|                                       | his teeth.                                  |                                      |                  |                                 |             | 1                |
|                                       |   | ber the last time he had             |                  |                                 |             | 1                |
|                                       | been shaved.                                |                                      |                  |                                 |             | I                |
|                                       | -He liked to be clean                       |                                      |                  |                                 |             | I                |
|                                       |   | ngth of his beard and he             |                  |                                 |             | 1                |
|                                       | "hated" having a mus                        | stache.<br>offered to trim his hair, |                  |                                 |             | 1                |
|                                       |   | •                                    |                  |                                 |             | 1                |
|                                       | mustache, and beard<br>-The staff had never |                                      |                  |                                 |             | 1                |
|                                       | -His hair was long on                       |                                      |                  |                                 |             | 1                |
|                                       | •   | e past arranged for haircuts         |                  |                                 |             | 1                |
|                                       | and facial hair trims.                      | o paot arrangoa for flairoato        |                  |                                 |             | 1                |
|                                       |   |                                      |                  |                                 |             |                  |
|                                       | Interview with the Sur                      | pervisor-In-Charge (SIC) on          |                  |                                 |             | 1                |
|                                       | 06/16/21 at 1:10pm re                       |                                      |                  |                                 |             |                  |
|                                       | -   | ved to her building on               |                  |                                 |             |                  |
|                                       | 03/26/21 or 03/27/21.                       |                                      |                  |                                 |             | ı                |
|                                       |   | dent #1 to take a bath since         |                  |                                 | ľ           |                  |
|                                       | he was admitted.                            |                                      |                  |                                 | ĺ           |                  |
|                                       | -She even tried to get                      | t him to take a sponge bath.         |                  |                                 |             |                  |

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| DIVISION C | of Health Service Regu       | lation   |                   |   |                  | _        |
|------------|------------------------------|--|-------------------|---|------------------|----------|
| STATEMENT  | Γ OF DEFICIENCIES            | (X1) PROVIDER/SUPPLIER/CLIA                                | (X2) MULTIPLE     | CONSTRUCTION  | (X3) DATE SURVEY |          |
| AND PLAN ( | OF CORRECTION                | IDENTIFICATION NUMBER:                                     | A. BUILDING: _    |   | COMPLETED        |          |
|            |                              |  | _                 |   |                  |          |
|            |                              |  | B WINC            |   | R-C              |          |
|            |                              | FCL011023  | B. WING           |   | 06/22/2021       | _        |
| NAME OF P  | ROVIDER OR SUPPLIER          | STREET AD  | DRESS, CITY, STAT | TE ZIP CODE   |                  |          |
|            | 101.52.1.5.1.                |  | /ELY BRANCH R     |   |                  |          |
| FAIRVIEW   | FAMILY CARE HOME #           | 2  |                   | COAD  |                  | -        |
|            | 1                            | FLEICHE  | ER, NC 28732      |   |                  |          |
| (X4) ID    |                              | ATEMENT OF DEFICIENCIES                                    | ID                | PROVIDER'S PLAN OF CORRECT                                  | ( -/             |          |
| PREFIX     | `                            | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION) | PREFIX            | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPR |                  |          |
| TAG        | REGULATORI ORI               | -30 IDENTIFTING INFORMATION)                               | TAG               | DEFICIENCY)   | OPRIATE 5=       |          |
|            |                              |  | +                 | · · · · · · · · · · · · · · · · · · ·                       |                  | $\dashv$ |
| C 246      | Continued From page          | e 15   | C 246             |   |                  |          |
|            |                              |  |                   |   |                  |          |
|            |                              | e was unable to get him to                                 |                   |   |                  |          |
|            | bathe or take a sponge bath. |  |                   |   |                  |          |
|            |                              | Guardian about him not                                     |                   |   |                  |          |
|            |                              | dian had replied "that's just                              |                   |   |                  |          |
|            | how he is."                  |  |                   |   |                  |          |
|            |                              | ne refused because it was a                                |                   |   |                  |          |
|            | new environment or b         | pecause he just did not want                               |                   |   |                  |          |
|            | to take a bath.              |  |                   |   |                  |          |
|            | -She was unable to g         | et Resident #1 to cut his                                  |                   |   |                  |          |
|            | toenails.                    |  |                   |   |                  |          |
|            | -She did not know wh         | nen Resident #1's toenails                                 |                   |   |                  |          |
|            | had last been trimme         | d.   |                   |   |                  |          |
|            | -The resident would to       | ell her he would take a                                    |                   |   |                  |          |
|            | shower "but he just w        |  |                   |   |                  |          |
|            |                              | ils "were so long now" she                                 |                   |   |                  |          |
|            | was afraid to cut then       | •  |                   |   |                  |          |
|            | -She thought he need         |  |                   |   |                  |          |
|            | podiatrist.                  | led to be seen by a  |                   |   |                  |          |
|            | podiatrist.                  |  |                   |   |                  |          |
|            | Interview with the SIC       | C on 06/17/21 at 11:55am                                   |                   |   |                  |          |
|            | revealed:                    | , 011 00/17/21 at 11.00am                                  |                   |   |                  |          |
|            |                              | ding Desident #1 cared for                                 |                   |   |                  |          |
|            |                              | iding, Resident #1 cared for                               |                   |   |                  |          |
|            | his own beard.               | " 'C D: J + 4/4   b - d   b i -                            |                   |   |                  |          |
|            |                              | now" if Resident #1 had his                                |                   |   |                  |          |
|            | own teeth.                   |  |                   |   |                  |          |
|            |                              | e knew about the resident.                                 |                   |   |                  |          |
|            |                              | sident go in the bathroom                                  |                   |   |                  |          |
|            |                              | ent took a washcloth to                                    |                   |   |                  |          |
|            | "wash himself off."          |  |                   |   |                  |          |
|            | -                            | dent had not been getting                                  |                   |   |                  |          |
|            | personal care as he v        |  |                   |   |                  |          |
|            | according to his care        | plan.  |                   |   |                  |          |
|            |                              |  |                   |   |                  |          |
|            | Interview with the SIC       | C on 06/17/21 at 2:05pm                                    |                   |   |                  |          |
|            | revealed:                    |  |                   |   |                  |          |
|            | -She spoke with Resi         | ident #1's PCP on 05/10/21.                                |                   |   |                  |          |
|            | -She did not tell the P      | PCP about the issues she                                   |                   |   |                  |          |
|            | was having in providir       | ng personal care assistance                                |                   |   |                  |          |
|            |                              | the telephone conversation                                 |                   |   |                  |          |

Division of Health Service Regulation

on 05/10/21.

STATE FORM 6899 NM2Z11 If continuation sheet 16 of 44

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---|---|-------------------------------|--|
|                          |  |  | A. BUILDING                             |   | D C                           |  |
|                          |  | FCL011023  | B. WING                                 |   | R-C<br><b>06/22/2021</b>      |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA                         | TE, ZIP CODE  |                               |  |
| FAIRVIEW                 | FAMILY CARE HOME #   | 2  | ELY BRANCH I<br>L, NC 28732             | ROAD  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE                   |  |
| C 246                    | Continued From page 16   |  | C 246                                   |   |                               |  |
|                          | -She noticed the leng<br>#1's toenails "three w  | th and condition of Resident<br>eeks ago."                                     |   |   |                               |  |
|                          | Interview with the Administrator on 06/17/21 at 12:15pm revealed she expected staff to notify the resident's PCP within "2 or 3 days" of a resident's first refusal of personal care assistance.  Telephone interview with the PCP's Registered Nurse (RN) on 06/17/21 at 9:13am revealed: -Resident #1 last spoke with the PCP via teleconference on 05/18/21The PCP also spoke with facility staff via teleconference on 05/18/21The PCP did not know Resident #1 had not taken a bath since admission on 03/26/21The PCP did not know the staff were having |  |   |   |                               |  |
|                          |  |  |   |   |                               |  |
|                          | difficulties providing personal care to Resident #1.  2. Review of Resident #1's physician order dated 01/18/21 revealed: -There was an order for apixaban (used to prevent blood clots) 5mg 1 tablet twice a dayThere was an order for Combivent take 1 inhalation four times a day (used to treat wheezing and shortness of breath)There was an order for Digoxin (used to treat atrial fibrillation) 250mcg take one half tablet dailyThere was an order diltiazem (used to treat high blood pressure)180mg 24 hr. capsule take 1 capsule daily.            |  |   |   |                               |  |
|                          | Review of Resident #1's physician order dated 03/26/21 revealed Combivent take 2 inhalations four times a day.   |  |   |   |                               |  |
|                          |  | 1's Primary Care Provider<br>27/21 at 3:16pm revealed:<br>e with the SIC.      |   |   |                               |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE C A. BUILDING: |   |                                 | E SURVEY<br>PLETED       |
|--|---|--|------------------------------|---|---------------------------------|--------------------------|
|  |   | FCL011023  | B. WING                      |   |                                 | R-C<br>6/22/2021         |
| NAME OF P  | ROVIDER OR SUPPLIER   | STREET A   | ADDRESS, CITY, STATE         | E, ZIP CODE   |                                 |                          |
| FAIRVIEW   | / FAMILY CARE HOME #  | 2  | WELY BRANCH RO               | DAD   |                                 |                          |
|  | T   | FLETCH   | IER, NC 28732                |   |                                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC   | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACTI<br>CROSS-REFERENCED TO T<br>DEFICIENC | ION SHOULD BE<br>HE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| C 246  | Continued From pag  | e 17   | C 246                        |   |                                 |                          |
|  | -Resident #1 was ou<br>apixaban, Digoxin, a   | t of/or had not been taking<br>nd diltiazem.   |                              |   |                                 |                          |
|  | Review of Resident #1's April 2021 electronic Medication Administration Record (eMAR) revealed the Combivent was documented as not administered for 75 occurrences from 04/01/21 to 04/30/21.  Review of Resident #1's May 2021 eMAR revealed: -The apixaban was documented as not administered for 16 occurrences from 05/01/21 to 05/31/21The Digoxin was documented as not administered for 10 occurrences from 05/01/21 to 05/31/21The diltiazem was documented as not administered for 14 occurrences from 05/01/21 to 05/31/21. |  |                              |   |                                 |                          |
|  |   |  |                              |   |                                 |                          |
|  | revealed the Combiv   | #1's June 2021 eMAR ent was documented as not ccurrences from 06/01/21 to  |                              |   |                                 |                          |
|  | 06/18/21 at 10:40am -Resident #1 had rur in April 2021She had contacted to pharmacy to request medicationsShe waited on the re contracted facility ph pharmacy because so pharmacy was havin medicationsShe "usually" would   | pervisor-In-Charge (SIC) on and 11:37am revealed: nout of several medications the contracted facility refills of Resident #1's efills to arrive from the armacy before calling the he "assumed" the contracted g a "hard time" getting the call the pharmacy after she medication "three or four |                              |   |                                 |                          |

Division of Health Service Regulation

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|                               | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  |   | (X2) MULTIPLE       | CONSTRUCTION  | (X3) DATE SURVEY |                          |
|-------------------------------|--|---|---------------------|---|------------------|--------------------------|
| AND PLAN (                    | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDING:        |   | COMPLE           | ETED                     |
|                               |  | _   | B WING              |   | R-0              |                          |
|                               |  | FCL011023   | B. WING             |   | 06/2             | 2/2021                   |
| NAME OF PI                    | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                  |                          |
| FAIRVIEW FAMILY CARE HOME # 2 |  |   | ELY BRANCH I        | ROAD  |                  |                          |
|                               |  | FLETCHER  | R, NC 28732         |   |                  |                          |
| (X4) ID<br>PREFIX<br>TAG      | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE               | (X5)<br>COMPLETE<br>DATE |
| C 246                         | 246 Continued From page 18   |   | C 246               |   |                  |                          |
| C 311                         | medications from the pharmacy, but from a -She had then contact to request refillsShe did not rememb spoken with the resid -When a medication administer, it was the the pharmacy to requand get the medication -It was the facility's poper per at the first miss however she did not a because she did not a Attempted telephone | er the exact date she had ent's pharmacy.  was not available to facility's policy to contact est a refill of the medication on "here."  policy to contact the resident's ed dose" of a medication, contact Resident #1's PCP 'think about it."  interview with Resident #1's an (PCP) on 06/18/21 at ssful. | C 311               |   |                  |                          |
|                               | all residents guaranted Declaration of Residerand may be exercised.  This Rule is not met Based on interviews a facility failed to ensur maintained for 1 of 3 (Resident #3) for not   | hall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained d without hindrance.  as evidenced by: and record reviews, the e resident rights were   |                     |   |                  |                          |
|                               | The finding are:   |   |                     |   |                  |                          |
|                               | Review of Resident #   | 3's FL2 dated 04/23/21  |                     |   |                  |                          |

Division of Health Service Regulation

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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<br>COMPLETED   |             |
|---|---|--|---------------------|---|-------------|
|   |   |  | 7 t. BOILBING.      |   | R-C         |
|   |   | FCL011023  | B. WING             |   | 06/22/2021  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |             |
| FAIRVIEW  | FAMILY CARE HOME #  | 2  | LY BRANCH I         | ROAD  |             |
|   |   | FLETCHER   | R, NC 28732         |   |             |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE |
| C 311   | Continued From page   | e 19   | C 311               |   |             |
|   | revealed diagnoses in injury and personality  | ncluded traumatic brain<br>disorder.   |                     |   |             |
|   | Review of Resident # revealed: -The resident was ad   | -  |                     |   |             |
|   | -The resident had a g   |  |                     |   |             |
|   | Review of Resident #3's Care Plan dated 04/23/21 revealed he required supervision with bathing and grooming/personal hygiene.   |  |                     |   |             |
|   | bathing and grooming/personal hygiene.  Interview with Resident #3 on 06/16/21 at 9:25am revealed:  -He had lived at the facility for 20 yearsHe performed work around the facility for payHe took out the trash in a sister facility on the property "everyday."  -He swept the sidewalks and porches of the facility and the two other sister facilities on the property "once a month."  -He mowed the grass around the facility "once a month."  -He had not been paid for the last time he had mowed the grass around the facility, because the Transport staff had "been out."  -The transport staff was the one who paid him for his workIt had been "awhile" since he had been paid for his workHe did not remember how much money he received for his work the last time he was paidHe did not know how much he was routinely paid |  |                     |   |             |
|   | 06/16/21 a 9:15am re  | pervisor-In-Charge (SIC) on<br>vealed:<br>ad been on leave "for a              |                     |   |             |

Division of Health Service Regulation

-She did not know when the transport staff would

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| DIVISION   | Division of Health Service Regulation |                                 |                  |   |             |          |
|------------|---------------------------------------|---------------------------------|------------------|---|-------------|----------|
| STATEMENT  | Γ OF DEFICIENCIES                     | (X1) PROVIDER/SUPPLIER/CLIA     | (X2) MULTIPLE    | CONSTRUCTION                                | (X3) DATE S | SURVEY   |
| AND PLAN ( | OF CORRECTION                         | IDENTIFICATION NUMBER:          | A. BUILDING:     |   | COMPL       | ETED     |
|            |                                       |                                 | _                |   | _           | _        |
|            |                                       |                                 | D. WING          |   | R-C         |          |
|            |                                       | FCL011023                       | B. WING          |   | 06/2        | 22/2021  |
| NAME OF D  | ROVIDER OR SUPPLIER                   | STREET AD                       | DRESS, CITY, STA | TE ZID CODE                                 |             |          |
| NAME OF T  | TOVIDER OR SOLT EIER                  |                                 |                  |   |             |          |
| FAIRVIEW   | FAMILY CARE HOME #                    | 2                               | ELY BRANCH I     | ROAD  |             |          |
|            |                                       | FLETCHE                         | R, NC 28732      |   |             |          |
| (X4) ID    | SUMMARY ST.                           | ATEMENT OF DEFICIENCIES         | ID               | PROVIDER'S PLAN OF CORRECTION               | ٧           | (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 APPROPF DEFICIENCY) | RIATE       | DATE     |
|            |                                       |                                 |                  | DEI IGIEROT)                                |             |          |
| C 311      | Continued From page                   | e 20                            | C 311            |   |             |          |
| •          | J                                     | , 20                            |                  |   |             |          |
|            | return from leave.                    |                                 |                  |   |             |          |
|            |                                       |                                 |                  |   |             |          |
|            | Interview with the SIC                | C on 06/17/21 at 9:05am         |                  |   |             |          |
|            | revealed:                             |                                 |                  |   |             |          |
|            | -Resident #3 perform                  | ed "yard work" at the facility. |                  |   |             |          |
|            | -The resident routinel                | -                               |                  |   |             |          |
|            |                                       | weedeater in the flower         |                  |   |             |          |
|            | beds outside the facil                | litv.                           |                  |   |             |          |
|            |                                       | d watered the ducks kept in a   |                  |   |             |          |
|            | pen behind the sister                 | •                               |                  |   |             |          |
|            | •                                     | it the trash in the sister      |                  |   |             |          |
|            | facility next door "eve               |                                 |                  |   |             |          |
|            | _                                     | out for a cup of coffee."       |                  |   |             |          |
|            |                                       | sport staff paid Resident #3    |                  |   |             |          |
|            | for the work he perfor                |                                 |                  |   |             |          |
|            | -                                     | nt #3 had "signed papers"       |                  |   |             |          |
|            |                                       | •                               |                  |   |             |          |
|            | saying it was somethi                 | _                               |                  |   |             |          |
|            |                                       | outside person and he           |                  |   |             |          |
|            | enjoyed being outside                 | э.                              |                  |   |             |          |
|            |                                       |                                 |                  |   |             |          |
|            |                                       | ten undated note revealed:      |                  |   |             |          |
|            |                                       | to help around the property     |                  |   |             |          |
|            |                                       | one forced the resident to do   |                  |   |             |          |
|            | anything against his "                |                                 |                  |   |             |          |
|            | -The note was signed                  | ,                               |                  |   |             |          |
|            | Administrator, and an                 | n SIC from a sister facility.   |                  |   |             |          |
|            |                                       |                                 |                  |   |             |          |
|            | Interview with Reside                 | nt #3 on 06/17/21 at            |                  |   |             |          |
|            | 10:05am revealed:                     |                                 |                  |   |             |          |
|            | -He signed a paper "a                 |                                 |                  |   |             |          |
|            | -He did not remembe                   |                                 |                  |   |             |          |
|            | -He wanted to work a                  | around the facility, but he     |                  |   |             |          |
|            | wanted to get paid for                | r his work.                     |                  |   |             |          |
|            | -He remembered he                     | was paid for his work in April  |                  |   |             |          |
|            | 2021, however he cor                  | uld not remember how            |                  |   |             |          |
|            | much.                                 |                                 |                  |   |             |          |
|            |                                       |                                 |                  |   |             |          |
|            | Telephone interview v                 | with the Administrator on       |                  |   |             |          |
|            | 06/17/21 at 1:45pm re                 |                                 |                  |   |             |          |
|            |                                       | id for the tasks he completed   |                  |   |             |          |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     | (X3) DATE SURVEY<br>COMPLETED   |                          |
|--|--|--|---------------------|---|--------------------------|
|  |  | FCL011023  | B. WING             |   | R-C<br><b>06/22/2021</b> |
| NAME OF PI   | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  |                          |
| FAIRVIEW   | FAMILY CARE HOME #   | 2  | ELY BRANCH I        | ROAD  |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE              |
| C 311  | tasksHe was last paid \$20 weedeating for 30 min-The resident "always taskThe resident was pai porches and sidewalk-The resident was pai-Resident #3 would resident #3   | the day he completed the  "about two weeks ago" for nutes around the facility. " got paid regardless of the  "d \$10 for sweeping the s. id \$20 for mowing the grass. equest chores to do.  | C 311               |   |                          |
| C 330  | (a) A family care hom preparation and admi prescription and non-by staff are in accorda (1) orders by a licens, which are maintained (2) rules in this Section and procedures.  This Rule is not met TYPE A2 VIOLATION.  Based on observation reviews, the facility fawere administered as prescribing practitione residents (Resident # used to treat atrial fibrorescription and administered as prescribing practitioneresidents (Resident # used to treat atrial fibrorescription and administered as prescribing practitioneresidents (Resident # used to treat atrial fibrorescription and administered and prescribing practitioneresidents (Resident # used to treat atrial fibrorescription and administered and prescribing practitionerescriptions are prescribed as prescribing practitionerescriptions. | 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  as evidenced by: I ns, interviews, and record illed to ensure medications ordered by a licensed er for 1 of 3 sampled 1) related to medications | C 330               |   |                          |
|  | The findings are:  |  |                     |   |                          |

Division of Health Service Regulation

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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<br>COMPLETED   |             |
|---|---|---|---------------------|---|-------------|
|   |   |   | 7.1. 231251110.     |   | R-C         |
|   |   | FCL011023   | B. WING             |   | 06/22/2021  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, STA   | TE, ZIP CODE  |             |
| FAIRVIEW  | FAMILY CARE HOME #  | 2   | VELY BRANCH F       | ROAD  |             |
| 040.1-  | CLIMMADV CT   |   | ER, NC 28732        |   | J 0.77      |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE |
| C 330   | Continued From page   | 22  | C 330               |   |             |
|   | failure and iliac artery Interview with the Sup 06/16/21 at 1:10pm re   | agnoses included renal<br>aneurysm.<br>pervisor-In-Charge (SIC) on<br>evealed Resident #1 had |                     |   |             |
|   | been admitted to the facility on 03/26/21 or 03/27/21.  a. Review of Resident #1's physician order dated 01/18/21 revealed apixaban (used to prevent blood clots) 5mg 1 tablet twice a day.  Review of Resident #1's April 2021 eMAR revealed:  -There was an entry for apixaban 5mg 1 tablet twice daily scheduled for 8:00am and 8:00pm.  -The apixaban was documented as administered twice daily from 04/01/21 to 04/27/21.  -The apixaban was documented as not administered on 04/28/21 at 8:00am and 04/30/21 at 8:00am due to "waiting on medication-pharmacy notified."  -The apixaban was documented as not administered for 2 occurrences from 04/01/21 to 04/27/21.  Review of Resident #1's Primary Care Provider (PCP) note dated 04/27/21 at 3:16pm revealed:  -The PCP nurse spoke with the SIC.  -Resident #1 was out of/or had not been taking apixaban.  Review of Resident #1's May 2021 eMAR revealed:  -There was an entry for apixaban 5mg 1 tablet twice daily scheduled for 8:00am and 8:00pm.  -The apixaban was documented as administered |   |                     |   |             |
|   |   |   |                     |   |             |
|   |   |   |                     |   |             |

Division of Health Service Regulation

at 8:00pm.

STATE FORM 6899 NM2Z11 If continuation sheet 23 of 44

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |  | (X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING: |  |                              | E SURVEY<br>PLETED       |
|--------------------------|--|--|---|--|------------------------------|--------------------------|
|                          |  |  | A. BUILDING:                                |  |                              |                          |
|                          |  | FCL011023  | B. WING                                     |  |                              | R-C<br>5/ <b>22/2021</b> |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STAT                           | E, ZIP CODE  |                              |                          |
|                          |  |  | ELY BRANCH R                                |  |                              |                          |
| FAIRVIEW                 | / FAMILY CARE HOME #   | 2  | R, NC 28732                                 | C7.12  |                              |                          |
| (V4) ID                  | SUMMARY ST   | ATEMENT OF DEFICIENCIES  | ID  | PROVIDER'S PLAN OF CO  | ORRECTION                    | (X5)                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG                               | (EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | COMPLETE<br>DATE         |
| C 330                    | C 330 Continued From page 23   |  | C 330                                       |  |                              |                          |
|                          | 8:00am due to "waitir<br>notified."<br>-The apixaban was de  | 1 at 8:00am to 05/10/21 at<br>ag on medication-pharmacy  |   |  |                              |                          |
|                          | hand on 06/18/21 at a There was one open tablets.  There were 53 and of the open bottle which tablets dispensed on The label directions whice a day.  There were three undirections to administ twice daily.  One bottle contained dispensed on 01/07/2.  The second and third | bottle of apixaban 5mg  ne-half tablets remaining in originally contained 60 05/11/21. were apixaban 5mg 1 tablet opened bottles with label er apixaban 5mg 1 tablet |   |  |                              |                          |
|                          | 06/18/21 at 10:40am -She had administere twice a day to Reside the end of April 2021 she documented the administered on the e -Resident #1 ran out April 2021She never saw the u filled 01/07/21She contacted the co   | eMARs. of several medications in nopened bottle of apixaban ontracted facility pharmacy esident #1's medications.  |   |  |                              |                          |

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 24 of 44

| DIVISION      | n Health Service Negu   | ialion                          |                  |                                 |             |          |
|---------------|-------------------------|---------------------------------|------------------|---------------------------------|-------------|----------|
|               | OF DEFICIENCIES         | (X1) PROVIDER/SUPPLIER/CLIA     | (X2) MULTIPLE    | CONSTRUCTION                    | (X3) DATE S |          |
| AND PLAN C    | OF CORRECTION           | IDENTIFICATION NUMBER:          | A. BUILDING:     |                                 | COMPLI      | ETED     |
|               |                         |                                 |                  |                                 | 1 _         | _        |
|               |                         |                                 | D WING           |                                 | R-          |          |
|               |                         | FCL011023                       | B. WING          |                                 | 06/2        | 2/2021   |
| NAME OF P     | ROVIDER OR SUPPLIER     | STREET ADI                      | ORESS, CITY, STA | TE ZIP CODE                     |             |          |
| IVAIVIL OI II | TO VIDER OR OUT LIER    |                                 |                  |                                 |             |          |
| FAIRVIEW      | FAMILY CARE HOME #      | 2                               | ELY BRANCH       | ROAD                            |             |          |
|               |                         | FLETCHEI                        | R, NC 28732      |                                 |             |          |
| (X4) ID       | SUMMARY STA             | ATEMENT OF DEFICIENCIES         | ID               | PROVIDER'S PLAN OF CORRECTION   | 7           | (X5)     |
| PRÉFIX        | •                       | Y MUST BE PRECEDED BY FULL      | PREFIX           | (EACH CORRECTIVE ACTION SHOULD  |             | COMPLETE |
| TAG           | REGULATORY OR L         | LSC IDENTIFYING INFORMATION)    | TAG              | CROSS-REFERENCED TO THE APPROPE | RIATE       | DATE     |
|               |                         |                                 | 1                | DEFICIENCY)                     |             |          |
| C 330         | Continued From page     | e 24                            | C 330            |                                 |             |          |
|               | contracted facility pho | armany hafara calling the       |                  |                                 |             |          |
|               |                         | armacy before calling the       |                  |                                 |             |          |
|               |                         | he "assumed" the contracted     |                  |                                 |             |          |
|               | pharmacy was having     | g difficulty getting the        |                  |                                 |             |          |
|               | medications.            |                                 |                  |                                 |             |          |
|               |                         | esident #1 did not get his      |                  |                                 |             |          |
|               | medications from the    | •                               |                  |                                 |             |          |
|               | pharmacy, but from a    | nother pharmacy instead.        |                  |                                 |             |          |
|               | -She then contacted t   | the resident's pharmacy to      |                  |                                 |             |          |
|               | request a refill.       |                                 |                  |                                 |             |          |
|               | -She did not remembe    | er the exact date she spoke     |                  |                                 |             |          |
|               | with the resident's pha | armacy.                         |                  |                                 |             |          |
|               | -                       | l refill bottles of apixaban    |                  |                                 |             |          |
|               |                         | he spoke with Resident #1's     |                  |                                 |             |          |
|               | pharmacy.               | no opene man nosident // 10     |                  |                                 |             |          |
|               | -When a medication v    | was not available to            |                  |                                 |             |          |
|               |                         | facility's policy to contact    |                  |                                 |             |          |
|               |                         |                                 |                  |                                 |             |          |
|               | the pharmacy to requ    | est a refill of the medication. |                  |                                 |             |          |
|               | A 44 4 - 1 1            | internieus with Decident #41e   |                  |                                 |             |          |
|               |                         | interview with Resident #1's    |                  |                                 |             |          |
|               |                         | 9:13am and 06/18/21 at          |                  |                                 |             |          |
|               | 2:12pm was unsucce      | sstul.                          |                  |                                 |             |          |
|               |                         |                                 |                  |                                 |             |          |
|               |                         | interview with Resident #1's    |                  |                                 |             |          |
|               | pharmacy on 06/18/2     | 1 at 2:31pm was                 |                  |                                 |             |          |
|               | unsuccessful.           |                                 |                  |                                 |             |          |
|               |                         |                                 |                  |                                 |             |          |
|               | Refer to the review of  | f Resident #1's note to         |                  |                                 |             |          |
|               | Primary Care Provide    | er (PCP) dated 04/26/21 at      |                  |                                 |             |          |
|               | 3:37pm.                 | •                               |                  |                                 |             |          |
|               | •                       |                                 |                  |                                 |             |          |
|               | Refer to the review of  | f Resident #1's Primary Care    |                  |                                 |             |          |
|               |                         | dated 04/27/21 at 3:15pm.       |                  |                                 |             |          |
|               |                         |                                 |                  |                                 |             |          |
|               | Refer to the review of  | f Resident #1's addendum        |                  |                                 |             |          |
|               |                         |                                 |                  |                                 |             |          |
|               | progress note pharma    | acist entry dated 05/03/21.     |                  |                                 |             |          |
|               | Defends the medical of  | F Danislant #41a Director       |                  |                                 |             |          |
|               |                         | f Resident #1's Pharmacy        |                  |                                 |             |          |
|               |                         | Note dated 05/10/21 at          |                  |                                 |             |          |
|               | 8:52am.                 |                                 |                  |                                 |             |          |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE  | (X3) DATE SURVEY    |   |              |
|---|--|--|---------------------|---|--------------|
| AND PLAN (  | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING:        |   | COMPLETED    |
|   |  |  |                     |   | R-C          |
|   |  | FCL011023  | B. WING             |   | 06/22/2021   |
|   |  |  | ı                   |   | 1 COIZZIZOZI |
| NAME OF P   | ROVIDER OR SUPPLIER  |  | RESS, CITY, STA     | •   |              |
| FAIRVIEW  | FAMILY CARE HOME #   | 2  | ELY BRANCH I        | ROAD  |              |
|   |  | FLETCHEF   | R, NC 28732         |   | ,            |
| (X4) ID<br>PREFIX<br>TAG                              | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE  |
| C 330   | Continued From page  | e 25   | C 330               |   |              |
|   | b. Review of Resident #1's physician order dated 03/26/21 revealed Combivent take 2 inhalations four times a day.  |  |                     |   |              |
|   | Review of Resident # Medication Administra revealed:   | 1's March 2021 electronic<br>ation Record (eMAR)                               |                     |   |              |
|   | -There was no entry f  | or Combivent.  |                     |   |              |
|   |  | mented administrations of  |                     |   |              |
|   | Combivent.   |  |                     |   |              |
|   | Review of Resident #1's April 2021 eMAR revealed: -There was an entry for Combivent inhale 2 puffs four times daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pmThe Combivent was documented as not |  |                     |   |              |
|   | administered from 04,<br>04/22/21 at 8:00am d<br>medication-pharmacy   | ue to "waiting on  |                     |   |              |
|   | -The Combivent was   |  |                     |   |              |
|   | Review of Resident # revealed:   |  |                     |   |              |
|   | _  |  |                     |   |              |
|   | administered from 06.8:00am.   | /01/21 to 06/16/21 at  |                     |   |              |
|   | 06/16/21 at 8:26pm d medication-pharmacy   | 6/21 at 12:00pm and on<br>ue to "waiting on<br>notified."                      |                     |   |              |
|   | -The Combivent was administered for 2 oc 06/17/21.   | documented as not<br>currences from 06/01/21 to                                |                     |   |              |

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 26 of 44

| DIVISION      | n Health Service Regu    |  |                  |  |             |                  |
|---------------|--------------------------|--|------------------|--|-------------|------------------|
|               | OF DEFICIENCIES          | (X1) PROVIDER/SUPPLIER/CLIA                        | (X2) MULTIPLE    | CONSTRUCTION   | (X3) DATE S |                  |
| AND PLAN      | OF CORRECTION            | IDENTIFICATION NUMBER:                             | A. BUILDING:     |  | COMPL       | EIED             |
|               |                          |  |                  |  | l R-        | ·C               |
|               |                          | FCL011023  | B. WING          |  | 1           | 22/2021          |
| NAME OF D     | ROVIDER OR SUPPLIER      | STREET AD  | DRESS, CITY, STA | ATE ZID CODE   |             |                  |
| NAIVIE OF F   | ROVIDER OR SUFFLIER      |  | , ,              | ,  |             |                  |
| FAIRVIEW      | FAMILY CARE HOME #       | 2  | ELY BRANCH       | ROAD   |             |                  |
|               |                          |  | R, NC 28732      |  |             | T                |
| (X4) ID       |                          | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID               | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD |             | (X5)<br>COMPLETE |
| PREFIX<br>TAG |                          | LSC IDENTIFYING INFORMATION)                       | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APPROPR                              |             | DATE             |
|               |                          |  |                  | DEFICIENCY)  |             |                  |
| C 330         | Continued From page      | 26   | C 330            |  |             |                  |
| 0 000         | . •                      |  | 0 550            |  |             |                  |
|               | _                        | ent #1's available Combivent                       |                  |  |             |                  |
|               | on 06/16/21 at 11:31a    |  |                  |  |             |                  |
|               |                          | itions remaining in the                            |                  |  |             |                  |
|               | inhaler.                 | 1400   |                  |  |             |                  |
|               |                          | d 120 metered doses and                            |                  |  |             |                  |
|               | was dispensed on 04      | /19/21.  |                  |  |             |                  |
|               | Interview with the Su    | pervisor-In-Charge (SIC) on                        |                  |  |             |                  |
|               | 06/16/21 at 11:32am      | - , ,  |                  |  |             |                  |
|               | -Resident #1 took "his   |  |                  |  |             |                  |
|               | Combivent "this morn     |  |                  |  |             |                  |
|               | -"I need to reorder it." | _  |                  |  |             |                  |
|               |                          |  |                  |  |             |                  |
|               | Interview with the SIC   | C on 06/16/21 at 1:10pm                            |                  |  |             |                  |
|               | revealed she could go    | et the Combivent inhaler for                       |                  |  |             |                  |
|               | Resident #1 through      | the facility's contracted                          |                  |  |             |                  |
|               | pharmacy, but it was     | "so expensive" because the                         |                  |  |             |                  |
|               | resident did not have    | insurance.   |                  |  |             |                  |
|               |                          |  |                  |  |             |                  |
|               |                          | C on 06/16/21 at 3:15pm                            |                  |  |             |                  |
|               | revealed:                | and the second flowers also a fire all the dis-    |                  |  |             |                  |
|               |                          | mbivent from the facility's                        |                  |  |             |                  |
|               | contracted pharmacy      | he medication to the facility                      |                  |  |             |                  |
|               | that evening.            | The medication to the facility                     |                  |  |             |                  |
|               | -The resident receive    | d the Combivent as                                 |                  |  |             |                  |
|               | scheduled "except at     |  |                  |  |             |                  |
|               |                          | ···  |                  |  |             |                  |
|               | Telephone interview v    | with Resident #1's pharmacy                        |                  |  |             |                  |
|               | on 06/17/21 at 1:00pr    | m revealed:  |                  |  |             |                  |
|               |                          | the Combivent was 2 puffs                          |                  |  |             |                  |
|               | four times a day.        |  |                  |  |             |                  |
|               | -                        | a Combivent inhaler on                             |                  |  |             |                  |
|               | 05/11/21.                |  |                  |  |             |                  |
|               |                          | uations in one Combivent                           |                  |  |             |                  |
|               | •                        | d a 30 day supply with the                         |                  |  |             |                  |
|               | current order.           | uld have been recorded                             |                  |  |             |                  |
|               | from the pharmacy ev     | uld have been reordered                            |                  |  |             |                  |
|               |                          | to be reordered as it was not                      |                  |  |             |                  |
|               | THE COMBINEMENT HAU      | to be recruciou de it was not                      | 1                |  |             | 1                |

Division of Health Service Regulation

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|                          |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | I ' '               | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|--|---------------------|---|-------------------------------|--|
|                          |  |  | A. BOILDING         |   | R-C                           |  |
|                          |  | FCL011023  | B. WING             |   | 06/22/2021                    |  |
| NAME OF PI               | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STA    | TE, ZIP CODE  |                               |  |
| FAIRVIEW                 | FAMILY CARE HOME #   | 2  | ELY BRANCH          | ROAD  |                               |  |
|                          |  |  | R, NC 28732         |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE COMPLETE                   |  |
| C 330                    | Continued From page  | e 27   | C 330               |   |                               |  |
|                          | on automatic refillThe Combivent shou 30 days through their system.  | lld have been refilled every telephone reordering  |                     |   |                               |  |
|                          | revealed: -Resident #1 was out awhile in April 2021, It (used to treat shortnee) -The pharmacist from told her how to get rethe pharmacy's telepheshe did not know how medications until she from Resident #1's phenomenate with the SIC revealed when a mediadminister, it was the the pharmacy to request. | Resident #1's pharmacy fills on medications through none reordering system. We to reorder Resident #1's spoke with the pharmacist narmacy (05/10/21).  Con 06/18/21 at 11:37am lication was not available to facility's policy to contact est a refill of the medication.  Interview with Resident #1's 1:13am and 06/18/21 at |                     |   |                               |  |
|                          |  | Resident #1's note to<br>er (PCP) dated 04/26/21 at  |                     |   |                               |  |
|                          |  | Resident #1's Primary Care dated 04/27/21 at 3:15pm.   |                     |   |                               |  |
|                          |  | Resident #1's addendum Resident #1's addendum Residentry dated 05/03/21.   |                     |   |                               |  |
|                          |  | Resident #1's Pharmacy<br>Note dated 05/10/21 at   |                     |   |                               |  |

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 28 of 44

| Division of   | of Health Service Regu    | ilation   |                  |  |                  |                  |
|---------------|---------------------------|---|------------------|--|------------------|------------------|
| STATEMENT     | OF DEFICIENCIES           | (X1) PROVIDER/SUPPLIER/CLIA                         | (X2) MULTIPLE    | CONSTRUCTION   | (X3) DATE SURVEY |                  |
| AND PLAN (    | OF CORRECTION             | IDENTIFICATION NUMBER:                              | A. BUILDING:     |  | COMPLETED        |                  |
|               |                           |   | _                |  |                  | •                |
|               |                           |   | B. WING          |  | R-               |                  |
|               |                           | FCL011023   | D. WING          |  | 06/2             | 22/2021          |
| NAME OF PI    | ROVIDER OR SUPPLIER       | STREET AD   | DRESS, CITY, STA | TE, ZIP CODE   |                  |                  |
|               |                           | 256 GRAV  | ELY BRANCH       | ROAD   |                  |                  |
| FAIRVIEW      | FAMILY CARE HOME #        | 2   | R, NC 28732      |  |                  |                  |
|               |                           |   | <u> </u>         |  |                  | T                |
| (X4) ID       |                           | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL | ID               | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD |                  | (X5)<br>COMPLETE |
| PREFIX<br>TAG | •                         | LSC IDENTIFYING INFORMATION)                        | PREFIX<br>TAG    | CROSS-REFERENCED TO THE APPROPR                              |                  | DATE             |
|               |                           |   |                  | DEFICIENCY)  |                  |                  |
|               |                           |   |                  |  |                  |                  |
| C 330         | Continued From page       | e 28  | C 330            |  |                  |                  |
|               | c. Review of Residen      | t #1's physician order dated                        |                  |  |                  |                  |
|               |                           | goxin (used to treat atrial                         |                  |  |                  |                  |
|               |                           | ake one half tablet daily.                          |                  |  |                  |                  |
|               | normation) 2001110g ta    | and one name about daily.                           |                  |  |                  |                  |
|               | Review of Resident #      | t1's April 2021 eMAR                                |                  |  |                  |                  |
|               | revealed:                 | 1   |                  |  |                  |                  |
|               | -There was an entry f     | for Digoxin 250mcg 1 tablet                         |                  |  |                  |                  |
|               | every day scheduled       |   |                  |  |                  |                  |
|               |                           | cumented as administered                            |                  |  |                  |                  |
|               | 04/01/21 to 04/27/21      |   |                  |  |                  |                  |
|               | -The Digoxin was doo      | cumented as not                                     |                  |  |                  |                  |
|               | •                         | 8/21 and 04/30/21 due to                            |                  |  |                  |                  |
|               |                           | on-pharmacy notified."                              |                  |  |                  |                  |
|               | -The Digoxin was dod      |   |                  |  |                  |                  |
|               | •                         | currences from 04/01/21 to                          |                  |  |                  |                  |
|               | 04/30/21.                 | 0411011000 110111 0 170 172 1 10                    |                  |  |                  |                  |
|               | 0 <del>1</del> /00/21.    |   |                  |  |                  |                  |
|               | Review of Resident        | #1's Primary Care Provider                          |                  |  |                  |                  |
|               |                           | /27/21 at 3:16pm revealed:                          |                  |  |                  |                  |
|               | -The PCP nurse spok       | •   |                  |  |                  |                  |
|               | -                         | t of/or had not been taking                         |                  |  |                  |                  |
|               | Digoxin.                  | torior ridd flot been taking                        |                  |  |                  |                  |
|               | Digoxiii.                 |   |                  |  |                  |                  |
|               | Review of Resident #      | t1's May 2021 eMAR                                  |                  |  |                  |                  |
|               | revealed:                 |   |                  |  |                  |                  |
|               |                           | for Digoxin 250mcg 1 tablet                         |                  |  |                  |                  |
|               | every day scheduled       |   |                  |  |                  |                  |
|               |                           | cumented as administered                            |                  |  |                  |                  |
|               | 05/11/21 to 05/31/21.     |   |                  |  |                  |                  |
|               | -The Digoxin was dod      |   |                  |  |                  |                  |
|               |                           | 5/01/21 to 05/10/21 due to                          |                  |  |                  |                  |
|               |                           | on-pharmacy notified."                              |                  |  |                  |                  |
|               | -The Digoxin was dod      |   |                  |  |                  |                  |
|               |                           | occurrences from 05/01/21 to                        |                  |  |                  |                  |
|               | 05/31/21.                 | 350411511505 110111 00/0 1/2 1 t0                   |                  |  |                  |                  |
|               | 00/01/21.                 |   |                  |  |                  |                  |
|               | Observation of Resid      | ent #1's available Digoxin on                       |                  |  |                  |                  |
|               | 06/16/21 at 11:28am       | _   |                  |  |                  |                  |
|               |                           | e of Digoxin 250mcg with                            |                  |  |                  |                  |
|               |                           | e one-half tablet daily.                            |                  |  |                  |                  |
|               | idadi dil collolla lo lak | to one-nan tablet dally.                            | 1                |  |                  | 1                |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|---|---|-------------------------------|--------------------------|
|   |  | FCL011023  | B. WING   |   | R-C<br><b>06/22/2021</b>      |                          |
| FAIRVIEW FAMILY CARE HOME # 2 256 GRAV              |  |  | DRESS, CITY, STA<br>ELY BRANCH I<br>R, NC 28732 |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                             | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE 0                          | (X5)<br>COMPLETE<br>DATE |
|   | with 44 whole tablets in the bottle.  Telephone interview with pharmacy on 06/16/2 -They provided the eligible of the provided the | s dispensed on 05/11/21 and 8 half tablets available  with the facility's contracted 1 at 1:02pm revealed: MARs for the facility. ad for Resident #1's Digoxin yday dated 02/12/20. for the entry on Resident  Digoxin for Resident #1.  with Resident #1's pharmacy m revealed: msed Digoxin 250mcg 45 md 05/11/21. ald be a 90 day supply.  Dervisor-In-Charge (SIC) on revealed when a medication administer, it was the fact the pharmacy to request on.  C on 06/18/21 at 2:00pm  de directions on the bottle of f the eMAR. e-half tablet of Digoxin #1 as per the bottle label  interview with Resident #1's 1:13am and 06/18/21 at | C 330   | DEL ROILING I)  |                               |                          |

3:37pm.

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 30 of 44

| STATEMENT                | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  |                     | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|---------------------|---|-------------------------------|--------------------------|
| ANDIEAN                  | or contraction  | IDENTIFICATION NOMBER.   | A. BUILDING: _      |   | OOWII E                       | -120                     |
|                          |   | FCL011023  | B. WING             |   | R-<br>06/2                    | C<br><b>2/2021</b>       |
| NAME OF PI               | ROVIDER OR SUPPLIER   | STREET ADD   | RESS, CITY, STA     | TE, ZIP CODE  | •                             |                          |
| FAIRVIEW                 | FAMILY CARE HOME #  | 256 GRAVI  | ELY BRANCH I        | ROAD  |                               |                          |
|                          |   | FLETCHER   | R, NC 28732         |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)                          | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| C 330                    | Continued From page   | <del>2</del> 30  | C 330               |   |                               |                          |
|                          |   | f Resident #1's Primary Care<br>dated 04/27/21 at 3:15pm.  |                     |   |                               |                          |
|                          |   | f Resident #1's addendum<br>acist entry dated 05/03/21.  |                     |   |                               |                          |
|                          |   | f Resident #1's Pharmacy<br>Note dated 05/10/21 at   |                     |   |                               |                          |
|                          | 01/18/21 revealed dil   | t #1's physician order dated<br>tiazem (used to treat high<br>ng 24 hr. capsule take 1                   |                     |   |                               |                          |
|                          | Review of Resident #1's April 2021 eMAR revealed:  -There was an entry for diltiazem CD 180mg 1 capsule daily scheduled at 8:00am.  -The diltiazem was documented as administered from 04/01/21 to 04/27/21 and 04/29/21.  -The diltiazem was documented as not administered on 04/28/21 and 04/30/21 due to "waiting on medication-pharmacy notified."  -The diltiazem was documented as not administered for 2 occurrences from 04/01/21 to 04/30/21. |  |                     |   |                               |                          |
|                          | (PCP) note dated 04/<br>-The PCP nurse spok   | #1's Primary Care Provider<br>27/21 at 3:16pm revealed:<br>se with the SIC.<br>of/or had not been taking |                     |   |                               |                          |
|                          | capsule daily schedu  | for diltiazem CD 180mg 1   |                     |   |                               |                          |

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 31 of 44

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |  |
|---|---|---|---|---|-------------------------------|--|
|   |   |   | A. BOILBING.                            |   |                               |  |
|   |   | FCL011023   | B. WING                                 |   | R-C<br><b>06/22/2021</b>      |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, STA                        | TE, ZIP CODE  |                               |  |
|   |   | 256 GRAV  | ELY BRANCH I                            | ROAD  |                               |  |
| FAIRVIEW  | FAMILY CARE HOME #  | FLETCHEI  | R, NC 28732                             |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTIOI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE                   |  |
| C 330   | Continued From page   | e 31  | C 330                                   |   |                               |  |
|   | on medication-pharm -The diltiazem was do administered for 14 or 05/31/21.  Observation of Resid on 06/16/21 at 11:50a -There was one bottle capsules with label didailyThere were 90 capsu with 66 capsules ava  Interview with the Sur 06/18/21 at 10:40am -Resident #1 ran out April 2021She never saw the unfilled 01/07/21She contacted the conto request refills of Resident waited on the resident was designed. | ocumented as not 1 to 05/14/21 due to "waiting acy notified." ocumented as not occurrences from 05/01/21 to ent #1's available diltiazem am revealed: e of diltiazem CD 180mg irections to take one tablet ules dispensed on 05/11/21 |   |   |                               |  |
|   | pharmacy because si<br>pharmacy was having<br>medications.  | he assumed the contracted g difficulty getting the  |   |   |                               |  |
|   | -She was informed R medications from the pharmacy, but from a -She then contacted request a refillShe did not rememb with the resident's ph-When a medication administer, it was the  | the resident's pharmacy to er the exact date she spoke armacy.  |   |   |                               |  |

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` '   | CONSTRUCTION        | (X3) DATE SURVEY<br>COMPLETED   |                          |
|---|--|---|---------------------|---|--------------------------|
| AND PLAN  | OF CORRECTION  | IDENTIFICATION NUMBER.  | A. BUILDING: _      |   | COMPLETED                |
|   |  | FCL011023   | B. WING             |   | R-C<br><b>06/22/2021</b> |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD  | DRESS, CITY, STA    | TE, ZIP CODE  |                          |
| EAID\/IE\A  | ZEAMILY CARE HOME #  | 256 GRAV  | ELY BRANCH I        | ROAD  |                          |
| FAIRVIEW  | FAMILY CARE HOME #   | FLETCHE   | R, NC 28732         |   |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                            | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE              |
| C 330   | Continued From page  | e 32  | C 330               |   |                          |
|   | Attempted telephone  | interview with Resident #1's<br>:13am and 06/18/21 at   |                     |   |                          |
|   |  | Resident #1's note to<br>er (PCP) dated 04/26/21 at   |                     |   |                          |
|   |  | Resident #1's Primary Care<br>dated 04/27/21 at 3:15pm.   |                     |   |                          |
|   |  | Resident #1's addendum acist entry dated 05/03/21.  |                     |   |                          |
|   | Refer to the review of Resident #1's Pharmacy<br>Telephone Encounter Note dated 05/10/21 at<br>8:52am. |   |                     |   |                          |
|   | Provider (PCP) dated revealed:   | ·   |                     |   |                          |
|   | determine the physici<br>"two and a half month   |   |                     |   |                          |
|   | -The pharmacist repo<br>renewals and refills.<br>-The pharmacy could<br>emergency refills.             | rted all medications needed no longer authorize   |                     |   |                          |
|   | medications through the pharmacy.  -The SIC and PCP's residents medicationsThere was an adden          | evealed: te with the SIC. esident #1 received all his the facility's contracted nurse reviewed all of the |                     |   |                          |
|   |  | ocial worker work with the  |                     |   |                          |

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PRINTED: 07/09/2021 FORM APPROVED

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ' '               | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---------------------|---|-------------------------------|--------------------------|
|   |  |   | 71. 201221110.      |   | R-C                           |                          |
|   |  | FCL011023   | B. WING             |   | 06/22                         |                          |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                               |                          |
| FAIRVIEW  | FAMILY CARE HOME #   | 2   | ELY BRANCH F        | ROAD  |                               |                          |
|   |  | FLETCHER  | R, NC 28732         |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| C 330   | Continued From page  | 33  | C 330               |   |                               |                          |
|   | resident's caregiver a<br>should be taking" and  | nd "find out exactly what he<br>I compile an accurate list<br>upcoming appointment with   |                     |   |                               |                          |
|   | note pharmacist entry<br>-The pharmacist calle<br>04/27/21 to review Re  | esident #1' medications.<br>not been able to "connect"  |                     |   |                               |                          |
|   | Encounter Note dated revealed: -The resident was ref admission prevention veterans administration resident's primary car medication confusion pertinent medications -The pharmacist who encounter note spoke -The caregiver would  | erred to the medication telephone clinic at the local on medical clinic by the re physician given and not taking many as prescribed. made the telephone |                     |   |                               |                          |
|   | medications as ordered treat atrial fibrillation, treat high blood press to prevent blood clots. Combivent to treat who breath during April 20 2021 because the mereordered. These failures at the second of the sec | neezing and shortness of 21, May 2021, and June edications were not ures caused a substantial tand constitutes a Type A2                                |                     |   |                               |                          |

Division of Health Service Regulation

STATE FORM 6899 NM2Z11 If continuation sheet 34 of 44

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE A. BUILDING: _   | CONSTRUCTION                | (X3) DATE SURVEY<br>COMPLETED  |             |
|--|--|--|-----------------------------|--|-------------|
|  |  | ECI 044022   | B. WING                     |  | R-C         |
|  |  | FCL011023  |                             |  | 06/22/2021  |
| NAME OF P  | ROVIDER OR SUPPLIER  |  | DRESS, CITY, STA            |  |             |
| FAIRVIEW   | FAMILY CARE HOME #   | 2  | ELY BRANCH F<br>R, NC 28732 | ROAD   |             |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG         | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE COMPLETE |
| C 330  | Continued From page  | = 34   | C 330                       |  |             |
|  | accordance with G.S. this violation.   | . 131D-34 on 06/16/21 for  |                             |  |             |
|  | CORRECTION DATE<br>VIOLATION SHALL N<br>2021.  | NOT EXCEED JULY 22,  |                             |  |             |
| C 342  | 10A NCAC 13G .1004<br>Administration   | 4(j) Medication  | 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 ad or treatment; (5) reason or justificate medications or treatmedocumenting the result (6) date and time of a (7) documentation of medications or treatmomission, including refusion (8) name or initials of the medication or treasignature equivalent to | red; ministering the medication  tion for the administration of nents as needed (PRN) and ulting effect on the resident; administration; any omission of nents and the reason for the efusals; and the person administering atment. If initials are used, a to those initials is to be ntained with the medication |                             |  |             |
|  | reviews, the facility fa<br>medication administra  | ns, interviews, and record   |                             |  |             |

Division of Health Service Regulation

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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<br>COMPLETED |                          |  |
|--------------------------|---|---|--|--|-------------------------------|--------------------------|--|
|                          |   |   |  |  |                               | R-C                      |  |
|                          |   | FCL011023   | B. WING                                  |  | 06/22/                        | 2021                     |  |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, STA                         | TE, ZIP CODE   |                               |                          |  |
| FAIRVIEW                 | FAMILY CARE HOME #  | 2   | ELY BRANCH                               | ROAD   |                               |                          |  |
|                          | OLUMBA DV OT  |   | R, NC 28732                              |  |                               |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |  |
| C 342                    | Continued From page   | ÷ 35  | C 342                                    |  |                               |                          |  |
|                          | The findings are:   |   |  |  |                               |                          |  |
|                          | Review of Resident # 10/19/20 revealed dia failure and iliac artery   | ignoses included renal  |  |  |                               |                          |  |
|                          | 1. Review of Resident #1's physician order dated 01/18/21 revealed Digoxin 250mcg take one half tablet daily.   |   |  |  |                               |                          |  |
|                          | Review of Resident #1's March 2021 electronic Medication Administration Record (eMAR) revealed:  -There was an entry for Digoxin 250mcg 1 tablet every day scheduled at 8:00am.  -The Digoxin was documented as administered 03/01/21 to 03/31/21.  -The Digoxin was documented as administered 62 occurrences of 62 opportunities. |   |  |  |                               |                          |  |
|                          | every day scheduled<br>-The Digoxin was doo<br>04/01/21 to 04/27/21<br>-The Digoxin was doo<br>administered on 04/20<br>"waiting on medicatio<br>-The Digoxin was doo   | for Digoxin 250mcg 1 tablet at 8:00am. cumented as administered and on 04/29/21. cumented as not 8/21 and 04/30/21 due to n-pharmacy notified." |  |  |                               |                          |  |
|                          | (PCP) note dated 04/The PCP nurse spok  | #1's Primary Care Provider<br>27/21 at 3:16pm revealed:<br>se with the SIC.<br>of/or had not been taking  |  |  |                               |                          |  |

Division of Health Service Regulation

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|                          | OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE       | CONSTRUCTION  | (X3) DATE SURVEY |
|--------------------------|--|---|---------------------|---|------------------|
| AND PLAN (               | OF CORRECTION  | IDENTIFICATION NUMBER:  | A. BUILDING:        |   | COMPLETED        |
|                          |  |   |                     |   | R-C              |
|                          |  | FCL011023   | B. WING             |   | 06/22/2021       |
|                          |  |   | 1                   |   | 1 OO/LE/LOZ I    |
| NAME OF PI               | ROVIDER OR SUPPLIER  |   | RESS, CITY, STA     |   |                  |
| FAIRVIEW                 | FAMILY CARE HOME #   | 2   | ELY BRANCH I        | ROAD  |                  |
|                          |  | FLETCHEF  | R, NC 28732         |   |                  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY) | BE COMPLETE      |
| C 342                    | Continued From page  | e 36  | C 342               |   |                  |
| 0 0.12                   | Review of Resident #revealed: -There was an entry fevery day scheduled -The Digoxin was doo 05/11/21 to 05/31/21The Digoxin was doo administered from 05. "waiting on medicatio -The Digoxin was doo administered for 10 o 05/31/21.  Observation of Reside 06/16/21 at 11:28am -There was one bottle label directions to tak -There were 45 tablet with 44 whole tablets in the bottle.  Telephone interview w pharmacy on 06/16/2 -They provided the effections of the service of | or Digoxin 250mcg 1 tablet at 8:00am. Cumented as administered Cumented as not (01/21 to 05/10/21 due to n-pharmacy notified." Cumented as not ccurrences from 05/01/21 to ent #1's available Digoxin on revealed: e of Digoxin 250mcg with e one-half tablet daily. is dispensed on 05/11/21 and 8 half tablets available with the facility's contracted 1 at 1:02pm revealed: |                     |   |                  |
|                          | 250mcg 1 tablet ever   |   |                     |   |                  |
|                          | #1's eMAR.   | ioi alo ollay oli recoluciti  |                     |   |                  |
|                          |  | Digoxin for Resident #1.  |                     |   |                  |
|                          | on 06/17/21 at 1:17pr -The current order for tablet daily dated 05/ -The prior order was tablet daily dated 02/2 -The pharmacy had dust 45 tablets on 02/20/2  | Digoxin 250mcg one-half<br>11/21.<br>for Digoxin 250mcg one-half<br>20/21.<br>ispensed Digoxin 250mcg   |                     |   |                  |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|--|---|-------------------------------|--------------------------|
|   |  | FCL011023  | B. WING                                  |   | R-<br>06/2                    | .C<br><b>2/2021</b>      |
|   | PROVIDER OR SUPPLIER   | 256 GRAVE  | DRESS, CITY, STA                         | •   |                               |                          |
| FAIRVIEV  | V FAMILY CARE HOME #   | FLETCHER   | R, NC 28732                              |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| C 342   | Interview with the Sup 06/17/21 at 2:00pm re-She was following the the Digoxin instead of "sometimes" the eMA-She was administering 250mcg daily to Residuabel directions.  Interview with the SIC revealed: -It was her responsible orders to the contract could update the eMA-She noticed the bottl Digoxin did not match administered the Digoshe noticed the labed different, but she did   | pervisor-In-Charge (SIC) on evealed: ne directions on the bottle of of the eMAR, because ARs were "wrong". ng one-half tablet of Digoxin dent #1 as per the bottle C on 06/18/21 at 11:37am illity to fax new or change ted facility pharmacy, so they AR. le directions did for the | C 342                                    |   |                               |                          |
|   | orders were different.  2. Review of Resident dated 03/26/21 reveal high blood pressure)  Review of Resident # Medication Administrate revealed:  -There was an entry for tablet every day scheen the metoprolol ER 1 administered 04/01/2 daily.  -The metoprolol ER 1 discontinued on 04/27.  -There was an entry for take 1/2 tablet at bediene to the series of the series | at #1's physician's order alled metoprolol (used to treat 50mg twice daily.  #1's April 2021 electronic ation Record (eMAR)  for metoprolol ER 100mg 1 eduled at 8:00am.  100mg was documented as 1 to 04/26/21 at 8:00am  |  |   |                               |                          |

Division of Health Service Regulation

bedtime was documented as administered daily

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| Division of   | of Health Service Regu | ilation                         |                  |   |                  |                  |
|---------------|------------------------|---------------------------------|------------------|---|------------------|------------------|
| STATEMENT     | OF DEFICIENCIES        | (X1) PROVIDER/SUPPLIER/CLIA     | (X2) MULTIPLE    | CONSTRUCTION                                | (X3) DATE SURVEY |                  |
| AND PLAN (    | OF CORRECTION          | IDENTIFICATION NUMBER:          | A. BUILDING:     |   | COMPL            | ETED             |
|               |                        |                                 | ·                |   | 1 _              |                  |
|               |                        |                                 | B WING           |   | R-               |                  |
|               |                        | FCL011023                       | B. WING          |   | 06/2             | 22/2021          |
| NAME OF P     | ROVIDER OR SUPPLIER    | STREET AF                       | DRESS, CITY, STA | TE ZIP CODE                                 |                  |                  |
| TO WILL OF TH | NOVIDER OR GOLF EIER   |                                 |                  |   |                  |                  |
| FAIRVIEW      | FAMILY CARE HOME #     | 2                               | ELY BRANCH       | ROAD  |                  |                  |
|               |                        | FLETCHE                         | R, NC 28732      |   |                  | 1                |
| (X4) ID       |                        | ATEMENT OF DEFICIENCIES         | ID               | PROVIDER'S PLAN OF CORRECTION               |                  | (X5)             |
| PREFIX        | •                      | Y MUST BE PRECEDED BY FULL      | PREFIX           | (EACH CORRECTIVE ACTION SHOULD              |                  | COMPLETE<br>DATE |
| TAG           | REGULATORT OR I        | LSC IDENTIFYING INFORMATION)    | TAG              | CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | MAIL             | DAIL             |
|               |                        |                                 |                  | ,   |                  |                  |
| C 342         | Continued From page    | e 38                            | C 342            |   |                  |                  |
|               | . •                    |                                 |                  |   |                  |                  |
|               | at 8:00pm from 04/01   |                                 |                  |   |                  |                  |
|               |                        | 100mg take 1/2 tablet at        |                  |   |                  |                  |
|               | bedtime was disconti   |                                 |                  |   |                  |                  |
|               |                        | for metoprolol 50mg 1 tablet    |                  |   |                  |                  |
|               | twice a day schedule   | d at 8:00am and 8:00pm.         |                  |   |                  |                  |
|               | -The metoprolol 50mg   | g 1 tablet was documented       |                  |   |                  |                  |
|               | as administered 04/0   | 1/21 to 04/30/21 at 8:00am      |                  |   |                  |                  |
|               | and 8:00pm.            |                                 |                  |   |                  |                  |
|               | •                      |                                 |                  |   |                  |                  |
|               | Observation of Resid   | ent #1's medications on         |                  |   |                  |                  |
|               | hand on 06/16/21 at    | 11:15am revealed:               |                  |   |                  |                  |
|               | -There was one bubb    | le pack of 50mg tablets with    |                  |   |                  |                  |
|               |                        | out of 31 tablets dispensed     |                  |   |                  |                  |
|               | on 05/05/21.           |                                 |                  |   |                  |                  |
|               |                        | bubble pack of metoprolol       |                  |   |                  |                  |
|               | 50mg tablets with 30   |                                 |                  |   |                  |                  |
|               | 06/07/21.              | tablets disperised off          |                  |   |                  |                  |
|               |                        | ibble pack of metoprolol        |                  |   |                  |                  |
|               | 50mg tablets with 30   |                                 |                  |   |                  |                  |
|               | 06/07/21.              | tablets dispensed on            |                  |   |                  |                  |
|               |                        | on all three bubble packs       |                  |   |                  |                  |
|               |                        | g take one tablet twice daily.  |                  |   |                  |                  |
|               | were metoprotot som    | g take one tablet twice daily.  |                  |   |                  |                  |
|               | Observation of Desid   | ant #41a madications an         |                  |   |                  |                  |
|               |                        | ent #1's medications on         |                  |   |                  |                  |
|               | hand on 06/18/21 at    |                                 |                  |   |                  |                  |
|               |                        | e of metoprolol 100mg           |                  |   |                  |                  |
|               | tablets.               |                                 |                  |   |                  |                  |
|               |                        | were metoprolol 100mg take      |                  |   |                  |                  |
|               | one-half a tablet ever |                                 |                  |   |                  |                  |
|               |                        | ining tablets of a bottle of 90 |                  |   |                  |                  |
|               | tablets.               |                                 |                  |   |                  |                  |
|               | -The dispense date w   | vas 05/11/21.                   |                  |   |                  |                  |
|               |                        |                                 |                  |   |                  |                  |
|               | -                      | pervisor-In-Charge (SIC) on     |                  |   |                  |                  |
|               | 06/18/21 at 11:37am    | revealed:                       |                  |   |                  |                  |
|               | -When Resident #1 w    | vas first admitted the          |                  |   |                  |                  |
|               | metoprolol order was   | to administer 100mg a day.      |                  |   |                  |                  |
|               |                        | changed to metoprolol 50mg      |                  |   |                  |                  |
|               | two times a day.       |                                 |                  |   |                  | [                |
|               | -She gave the metop    | rolol as per the label          |                  |   |                  |                  |
|               |                        | •                               | 1                | 1   |                  | 1                |

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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<br>COMPLETED |                          |
|---|--|--|---|---|-------------------------------|--------------------------|
|   |  | FCL011023  | B. WING                                 |   | R-<br>                        |                          |
| NAME OF PF  | ROVIDER OR SUPPLIER  | STREET ADD   | RESS, CITY, STA                         | TE, ZIP CODE  |                               |                          |
| FAIRVIEW  | FAMILY CARE HOME #   | 2  | LY BRANCH F                             | ROAD  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID PREFIX TAG                           | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPR<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| C 342   | documented as admin 04/26/21 daily at 8:00 error.  -On the April eMAR, t take 1/2 tablet at bedi administered daily at 04/26/21 was a docur-Resident #1 had recedily as ordered since-It was her responsibility orders to the contract could update the eMA 10A NCAC 13G .170 Control Program (tem 10A NCAC 13G .170 PREVENTION AND 0 (c) When a communic been identified at the emerging infectious distribution of the facility is IPCP, reprocedures, and publication of the procedures of the communicable disease emerging infectious dissued in writing by the department, the special services in the service of the services and publication of the communicable disease emerging infectious dissued in writing by the department, the special services and publication of the communicable disease emerging infectious dissued in writing by the communicable disease emerging infectious dissued in writing by the department, the special services are serviced in the communication of the communic | he metoprolol ER 100mg histered 04/01/21 to he metoprolol ER 100mg hime documented as 8:00pm from 04/01/21 to hentation error. he metoprolol 50mg twice 2:04/01/21. hity to fax new or change hed facility pharmacy, so they have.  I (c) Infection Prevention & he metoprolol 50mg twice he 04/01/21. hity to fax new or change hed facility pharmacy, so they have.  I (c) Infection Prevention & he control PROGRAM he cable disease outbreak has he cility or there is an hisease hisease hisease he coutofices and he coutofice | C 342                                   |   |                               |                          |

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|                          | OF DEFICIENCIES OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|---|----------------------------|---|-------------------------------|--|
|                          |   |   | A. BUILDING: _             |   |                               |  |
|                          |   | FCL011023   | B. WING                    |   | R-C<br><b>06/22/2021</b>      |  |
| NAME OF P                | ROVIDER OR SUPPLIER   |   | DDRESS, CITY, STA          | TE ZIP CODE   | 1                             |  |
|                          |   | 256 GRA   | VELY BRANCH F              |   |                               |  |
| FAIRVIEW                 | FAMILY CARE HOME #  | 2   | ER, NC 28732               | (OAD  |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIC<br>(EACH CORRECTIVE ACTION SHOULE<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE                 |  |
| C 612                    | Continued From page   | e 40  | C 612                      |   |                               |  |
|                          | facility failed to ensur<br>guidance by the Cent<br>(CDC) and the North<br>Health and Human S<br>implemented and ma<br>Coronavirus (COVID-<br>protection to the resion<br>of transmission and in  | and record reviews, the e recommendations and ters for Disease Control Carolina Department of ervices (NCDHHS) were intained during the global 19) pandemic to provide dents and to reduce the risk infection as related to the dent or staff temperatures or |                            |   |                               |  |
|                          | Review of the CDC g the prevention and sp Disease in long term revealed: -A strong infection pro program is critical to p healthcare personnel -All essential visitors presence of fever and when entering the bu -Actively monitor all refever and symptoms -Staff should wear a f they were in the facili  Review of the NC DH 05/05/21 for the prevence of | evention and control protect both residents and should be screened for the d symptoms of the virus ilding. esidents at least daily for consistent with COVID-19. facemask at all times while ty.  |                            |   |                               |  |

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

| STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|--|----------------------------|---|-------------------------------|--|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER.   | A. BUILDING: _             |   | COMPLETED                     |  |
|  |  | FCL011023  | B. WING                    |   | R-C<br><b>06/22/2021</b>      |  |
| NAME OF P  | ROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, STA           | TE, ZIP CODE  |                               |  |
| EAID\/IE\A   | / FAMILY CARE HOME #   | 256 GRAV   | ELY BRANCH I               | ROAD  |                               |  |
| FAIRVIEW   | FAMILI CARE HOME #   | FLETCHE  | R, NC 28732                |   |                               |  |
| (X4) ID<br>PREFIX<br>TAG                             | (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | D BE COMPLETE                 |  |
| C 612  | Continued From page  | e 41   | C 612                      |   |                               |  |
| 00.  | healthcare facility for  | signs and symptom of ature checks, screening   |                            |   |                               |  |
|  | Interview with a resident on 06/16/21 at 8:42am revealed facility staff did not screen him daily for symptoms of COVID-19.   |  |                            |   |                               |  |
|  | 8:54am revealed CO'<br>on residents at the be  | nd resident on 06/16/21 at VID-19 screening was done eginning of the pandemic but but 2 months ago after the accines.  |                            |   |                               |  |
|  | 06/17/21 at 9:24am re-All residents had the staff, that lived at the vaccineShe screened the re taking their temperatu questions "maybe" 1-She changed the scr times a week after the vaccinesShe completed a scr "for a while" but stopp completedShe had a "COVID be the facility's infection -She "thought" the infa sister facility but wo | ir vaccines but "only one" facility, had taken the sidents for COVID-19 by ure and asking them 2 times a week. reening from daily to 1-2 re residents received their reening log on live-in staff ored after the vaccines were recontrol policy was. rection control policy was at ould need to check. |                            |   |                               |  |
|  | Interview with the Adr   | e it could not be located.  ministrator on 06/17/21 at e did not know where the y would be located.  |                            |   |                               |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  |   | 1                   | CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---------------------|---|-------------------------------|--------------------------|
| AND PLAN C  | OF CORRECTION  | IDENTIFICATION NOMBER.  | A. BUILDING: _      |   | COMPLET                       | בט                       |
|   |  | FCL011023   | B. WING             |   | R-C<br><b>06/22</b> /         | 2021                     |
| NAME OF P   | ROVIDER OR SUPPLIER  | STREET ADD  | RESS, CITY, STA     | TE, ZIP CODE  |                               |                          |
| FAIRVIEW  | FAMILY CARE HOME #   | 256 GRAVE   | LY BRANCH           | ROAD  |                               |                          |
| FLETCHER  |  |   | R, NC 28732         |   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |
| C 912   | G.S. 131D-21(2) Dec  | laration of Residents' Rights   | C 912               |   |                               |                          |
|   | Every resident shall h<br>2. To receive care an<br>adequate, appropriate                             | ration of Resident's Rights have the following rights: had services which are e, and in compliance with state laws and rules and  |                     |   |                               |                          |
|   | review, the facility fail<br>received care and ser<br>appropriate and in co                          | ns, interviews and record ed to ensure residents rvices which were adequate, mpliance with relevant s and rules and regulations   |                     |   |                               |                          |
|   | The findings are:  |   |                     |   |                               |                          |
|   | reviews, the facility fa<br>was provided for 1 of<br>related to bathing, mo<br>shaving.[Refer to Tag | ns, interviews and record<br>illed to ensure personal care<br>3 sampled residents (#1) as<br>buth care, toenail care, and<br>0242, 10A NCAC 13G<br>are and Supervision (Type A2 |                     |   |                               |                          |
| C 914   | G.S 131D-21(4) Deck  | aration Of Resident's Rights  | C 914               |   |                               |                          |
|   |  | nave the following rights:<br>al and physical abuse,<br>ion.  |                     |   |                               |                          |
|   |  | ns, interviews, and record illed to assure residents  |                     |   |                               |                          |
|   | The findings are:  |   |                     |   |                               |                          |

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|                          | FOF DEFICIENCIES<br>DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                                | (X2) MULTIPLE C<br>A. BUILDING:  |   |                                   | E SURVEY<br>PLETED       |
|--------------------------|---|---|----------------------------------|---|-----------------------------------|--------------------------|
|                          |   | FCL011023   | B. WING                          |   |                                   | R-C<br>6/ <b>22/2021</b> |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET  | ADDRESS, CITY, STATE             | , ZIP CODE  |                                   |                          |
| FAIRVIEW                 | FAMILY CARE HOME  | # 2   | AVELY BRANCH RO<br>HER, NC 28732 | OAD   |                                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG              | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE ACT<br>CROSS-REFERENCED TO T<br>DEFICIENCE | ΓΙΟΝ SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| C 914                    | Continued From pag  | ge 43   | C 914                            |   |                                   |                          |
|                          | reviews, the facility f<br>were administered a<br>prescribing practition<br>residents (Resident<br>used to treat atrial fil<br>pressure, prevent bla<br>shortness of breath.) | ood clots, wheezing and<br>[Refer to Tag 0330, 10A<br>Medication Administration   |                                  |   |                                   |                          |

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