STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL011023	A. BUILDING: _____ B. WING _____	R-C 06/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW FAMILY CARE HOME # 2	256 GRAVELY BRANCH ROAD FLETCHER, NC 28732

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 06/16/21 to 06/18/21 and 06/21/21 with a telephone exit on 06/22/21.	C 000		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 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; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to maintain the facility in a clean manner, free of obstructions and hazards related to mold and mildew build-up on the tile and grout in the shower in the men's common bathroom and a rotting floor in the women's common bathroom. The findings are: 1. Observation of the men's common shower on 06/16/21 at 8:40am revealed: -There was a missing ceramic tile. -There was a large build-up of mold and mildew on the tile and grout. -The caulking between the tile and the tub was stained with mold and mildew. Interview with the Supervisor In Charge (SIC) on	C 078		

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C 078	Continued From page 1 06/17/21 at 8:59am revealed: -She was responsible for cleaning the bathrooms daily. -She knew the tile and grout surrounding the shower in the men's common bathroom had a build-up of mold and mildew. -She had done everything she could to clean it and had not been successful. Interview with the Administrator on 06/17/21 at 12:15pm revealed: -She did not know the shower in the men's common bathroom had a build-up of mold. -The SIC was responsible for everything in the facility. 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 commode. -The floor under the plywood was soft and flexible. -A piece of flooring approximately 4 inches by 8 inches was missing and the surrounding flooring was cracked. -The subfloor exposed under the missing flooring was rotten. Interview with the Supervisor In Charge (SIC) on 06/17/21 at 8:59am revealed: -The floor in front of the commode in the women's common bathroom was rotting. -She noticed it a week ago and put a piece of plywood over the rotting spot until it could be repaired. -A family member was going to repair the floor as soon as she obtained the supplies. Interview with a resident on 06/17/21 at 9:15am revealed:	C 078		

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C 078	Continued From page 2 -The floor in the women's common bathroom was rotting in front of the commode. -The SIC noticed it and put a piece of plywood over the rotting spot "a few days ago". -She had not tripped on the plywood. -She was told a family member of the SIC was going to fix the floor. Interview with the Administrator on 06/17/21 at 12:15pm revealed: -She did not know the floor in the women's common bathroom was rotting. -The SIC was responsible for everything in the facility, but she expected the SIC to inform her of things that needed to be repaired. -A rotting floor would be something that needed to be repaired immediately. Interview with the facility's family member on 06/18/21 at 2:25pm revealed: -The rotting floor in the women's common bathroom was brought to his attention a week ago. -He would repair the floor as soon at the SIC obtains the supplies. -He thought the piece of plywood on the floor "would be a trip hazard".	C 078		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of	C 202		

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C 202	Continued From page 3 the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (Resident #1) was tested for Tuberculosis (TB) upon admission. The findings are: Review of Resident #1's current FL2 dated 10/19/20 revealed diagnoses included renal failure and iliac artery aneurysm. Review of Resident #1's record revealed: -There was a Quantiferon-TB Gold test (a blood test that aids in the detection of Mycobacterium TB and is an alternative to tuberculin skin tests) started on 07/13/18 at 2:27pm. -The Quantiferon-TB Gold blood test was stopped on 07/17/18 at 3:08pm. -There were no documented results of Resident #1's Quantiferon-TB Gold blood test. -There were no other documented results of any additional TB testing in Resident #1's record. Telephone interview with Resident #1's Guardian on 06/16/21 at 3:20pm revealed Resident #1 had lived at an independent living facility before being admitted to the sister facility in February 2019. Interview with the Supervisor-In-Charge (SIC) on 06/16/21 at 1:10pm revealed: -Resident #1 had moved to her building on 03/26/21 or 03/27/21 from a sister facility.	C 202		

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C 202	Continued From page 4 -She was told by the previous SIC, Resident #1 did not have to have another TB test since he had a Quantiferon-TB Gold test in the past. -She was responsible to ensure TB testing was completed for residents prior to admission to the facility. 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 admission. -It was the facility's policy to obtain TB testing within 30 days of admission. -It was difficult to schedule a nurse to place a TB skin test. -A nurse reviewed the resident records "every 3 months" and the missing TB test information should have been brought to the staff's attention. -It was the SIC's responsibility to ensure TB testing was completed.	C 202		
C 204	10A NCAC 13G .0702 (c-1) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination (c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (1) The examining date recorded on the FL-2 or MR-2 shall be no more than 90 days prior to the person's admission to the home. This Rule is not met as evidenced by: Based on interviews and record review, the	C 204		

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C 204	Continued From page 5 facility failed to ensure the examining date recorded on the FL2 was no more than 90 days prior to admission for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's FL2 dated 03/05/20 revealed: -Diagnoses included cognitive changes due to traumatic brain injury primary, atrial fibrillation, cardiomyopathy, hypertension, anoxic brain damage complication, and hypercholesterolemia. -The resident was ambulatory and continent of bladder and bowel. Review of Resident #1's current FL2 dated 10/19/20 revealed diagnoses included renal failure and iliac artery aneurysm. Review of Resident #1's record revealed there was no FL2 or clarification of the resident's orders by the Primary Care Provider (PCP) within 90 days of the resident admission. Interview with the Supervisor-In-Charge (SIC) on 06/16/21 at 1:10pm revealed: -Resident #1 had moved to her building on 03/26/21 or 03/27/21 from a sister facility. -The SIC from the sister facility had told her the FL2 dated 02/11/20 in the resident record was the current FL2. -The SIC from the sister facility had told her Resident #1 had been taken to the doctor in February 2021 for a follow-up visit. -She noticed the date on the FL2 was 02/11/20, but she was told by the previous SIC the year on the FL2 was supposed to be 2021. -It was her responsibility to obtain a new FL2 on admission if the FL2 was over 90 days old.	C 204		

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C 204	Continued From page 6 -She did not get a new FL2 for Resident #1 upon admission. -She 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. Attempted telephone interview with Resident #1's PCP on 06/17/21 at 9:13am and 06/18/21 at 2:12pm was unsuccessful.	C 204		
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.	C 242		

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C 242	Continued From page 7 The findings are: Review of Resident #1's current FL2 dated 10/19/20 revealed diagnoses included renal failure and iliac artery aneurysm. Review of Resident #1's Care Plan dated 02/10/21 revealed: -The resident required supervision with eating and bathing. -The resident required extensive assistance with grooming and personal hygiene. Observation of Resident #1 on 06/16/21 at 8:42am revealed: -The resident had a strong body odor of perspiration. -The resident was not wearing shoes or socks. -The great toenail on the resident's left foot was yellowed, thickened, had an uneven edge, and protruded approximately 1/2 inch past the flesh of his toe. -The second toenail on the resident's left foot was yellowed, thickened, had an uneven edge, and protruded approximately 1/2 inch past the flesh of his toe. -The great toenail on the resident's right foot was yellowed, thickened, and protruded approximately 1/2 inch past the flesh of his toe. -The second toenail on the resident's right foot was yellowed, thickened, and protruded approximately 1/8 inch past the flesh of his toe. -The resident's beard was thick and approximately 3/4 inch long on his face and neck. Interview with the Supervisor-In-Charge (SIC) on 06/16/21 at 1:10pm revealed Resident #1 had moved to the facility on 03/26/21 or 03/27/21. Interview with Resident #1 on 06/16/21 at 8:42am	C 242		

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C 242	Continued From page 8 revealed: -He needed assistance with cutting his toenails. -The last time he remembered his toenails being trimmed was "six months ago." -The last shower he had received was when he lived "in the other building." -He had not received a shower since he moved to the new facility. -His dirty clothes and his bed linens had not been washed since he moved to the facility. Interview with Resident #1 on 06/17/21 at 11:18am revealed: -He could not remember the last time his dirty clothes were washed. -Staff had not offered to wash his clothes since he had been in the facility. -He had not received a shower since he came to live in the new facility. -He had not taken a sponge bath nor had staff offered him a sponge bath. -He could not remember the last time he brushed his teeth. -He could not remember the last time he had been shaved. -He liked to be clean shaven. -He did not like the length of his beard and he "hated" having a mustache. -The staff had never offered to trim his hair, mustache, and beard. -The staff had never offered to shave him. -His hair was long on the sides. -The previous facility had in the past arranged for haircuts and facial hair trims. -He saw his Guardian "two times a month." Observation of the clothes hamper in the corner of Resident #1's room on 06/17/21 at 11:42am revealed: -The hamper was full of dirty clothes.	C 242		

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C 242	Continued From page 9 -There was a small pile of dirty clothes lying in front of the hamper on the floor. Observation of the bedside table in Resident #1's room on 06/17/21 at 11:48am revealed: -There was a plastic cup on the bedside table top. -There were three toothbrushes and one tube of toothpaste available in the plastic cup. Telephone interview with Resident #1's Guardian on 06/17/21 at 3:20pm revealed: -Resident #1 was "hard" to get into the shower. -The resident was unstable on his feet and so he was "afraid" he might fall in the shower. -The staff at the previous facility would stand at the bathroom door "to keep an eye on him" as he showered. -The resident was not able to do his own toenail care. -The resident had been "seeing a podiatrist" at his local health care provider. -Facility staff provided transport to appointments. Interview with the Supervisor-In-Charge (SIC) on 06/16/21 at 1:10pm revealed: -When she received a new admission, it was her responsibility to check the care plan and provide the assistance needed. -She tried to get Resident #1 to take a bath since he was admitted. -She even tried to get him to take a sponge bath. -Since his admission, she was unable to get him to bathe or take a sponge bath. -She spoke with his Guardian about him not bathing and the Guardian replied "that's just how he is." -He bathed once a week for staff in the previous sister facility where he lived. -She was not sure if he refused because it was a new environment or because he just did not want	C 242		

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C 242	Continued From page 10	C 242		

to take a bath.
-Every time she asked him for his dirty laundry, the resident would tell her he did not have any dirty laundry.
-"I don't go in his room and look around without his permission."
-She was unable to get Resident #1 to cut his toenails.
-She did not know when Resident #1's toenails were last trimmed.
-The length of Resident #1's toenails were "ridiculous."
-His Guardian told her Resident #1 was afraid of falling.
-She told the resident she would sit with him while he was showering.
-She told him his toenails would be easier to cut after a shower.
-The resident would tell her he would take a shower "but he just won't do it."
-The resident's toenails "were so long now" she was afraid to cut them herself.
-She thought he needed to be seen by a podiatrist.
-She was not sure if Resident #1's local health care provider offered podiatry services or not.

Interview with the previous SIC from the sister facility on 06/16/21 at 2:10pm revealed:
-Resident #1 cut his own toenails.
-"Maybe" his Guardian would come to the facility and cut the resident's toenails for him.
-She was able to get the resident to take a bath once a week when he lived in her facility.
-The current SIC was unable to get Resident #1 to take a bath since he moved.

Interview with the SIC on 06/17/21 at 11:55am revealed:
-It was her understanding, Resident #1 cared for

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C 242	Continued From page 11 his own beard. -She did not "even know" if Resident #1 had his own teeth. -"That's how little" she knew about the resident. -She saw the resident go in the bathroom "twice" and the resident took a washcloth to "wash himself off." -She agreed the resident had not been getting personal care as he was supposed to get according to his care plan. -Resident #1 needed a shower and a shave. -Resident #1 needed to let her wash his dirty clothes. -"He has to trust me enough to let me do it." Interview with the SIC on 06/17/21 at 2:05pm revealed she noticed the length and condition of Resident #1's toenails "three weeks ago." Interview with the Administrator on 06/17/21 at 12:15pm revealed: -If a resident was not bathing, she expected staff to tell the resident they were going to get a shower. -She expected staff to give the resident a wash cloth and towel and tell the resident they would wait right outside the bathroom to assist if needed. -"If that did not work, I would give them a sponge bath." -She expected staff to prompt the resident to brush his teeth. -If the resident would not brush his teeth, she would expect staff to offer the resident mouthwash to use. -If a resident was unable to cut their toenails and they were not diabetic, she expected staff to cut the resident's toenails. -If the toenails were too long, she would expect staff to arrange for a visit to podiatry.	C 242		

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C 242	Continued From page 12 -She expected staff to shave residents who wanted to be shaved. -They had electric razors to shave residents and to trim facial hair. -One of the SIC's in a sister facility would often trim male resident's hair, otherwise staff should arrange an appointment for the resident at a "salon right down the road" from the facility. _____ The failure of the facility to provide Resident #1 with the assistance he required with bathing, mouth care, toenail care, and shaving for almost three months let the resident have a strong body odor, wearing dirty clothes and hating his appearance related to his unshaven face. This failure placed the resident at substantial risk for serious neglect and physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/17/21. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 22, 2021.	C 242		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the primary care provider (PCP) was notified of 1 of 3 sampled residents (Resident #1) had not received personal care including bathing, mouth care,	C 246		

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toenail care, and shaving since admission and missed multiple doses of medications used to treat atrial fibrillation, high blood pressure, prevent blood clots, and wheezing and shortness of breath (Resident #1).

The findings are:

Review of Resident #1's current FL2 dated 10/19/20 revealed diagnoses included renal failure and iliac artery aneurysm.

Review of Resident #1's Care Plan dated 02/10/21 revealed:
-The resident required supervision with eating and bathing.
-The resident required extensive assistance with grooming and personal hygiene.

1. Observation of Resident #1 on 06/16/21 at 8:42am revealed:
-The resident had a strong body odor of perspiration.
-The resident was not wearing shoes or socks.
-The great toenail on the resident's left foot was yellowed, thickened, had an uneven edge, and protruded approximately 1/2 inch past the flesh of his toe.
-The second toenail on the resident's left foot was yellowed, thickened, had an uneven edge, and protruded approximately 1/2 inch past the flesh of his toe.
-The great toenail on the resident's right foot was yellowed, thickened, and protruded approximately 1/2 inch past the flesh of his toe.
-The second toenail on the resident's right foot was yellowed, thickened, and protruded approximately 1/8 inch past the flesh of his toe.
-The resident's beard was thick and approximately 3/4 inch long on his face and neck.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 14 Interview with Resident #1 on 06/16/21 at 8:42am revealed: -He needed assistance with cutting his toenails. -The last time he remembered his toenails being trimmed was "six months ago." -The last shower he had received was when he lived "in the other building." -He had not received a shower since he moved to the new facility. -His dirty clothes and his bed linens had not been washed since he moved to the facility. Interview with Resident #1 on 06/17/21 at 11:18am revealed: -He had not received a shower since he came to live in the new facility. -He had not taken a sponge bath nor had staff offered him a sponge bath. -He could not remember the last time he brushed his teeth. -He could not remember the last time he had been shaved. -He liked to be clean shaven. -He did not like the length of his beard and he "hated" having a mustache. -The staff had never offered to trim his hair, mustache, and beard. -The staff had never offered to shave him. -His hair was long on the sides. -The facility had in the past arranged for haircuts and facial hair trims. Interview with the Supervisor-In-Charge (SIC) on 06/16/21 at 1:10pm revealed: -Resident #1 had moved to her building on 03/26/21 or 03/27/21. -She tried to get Resident #1 to take a bath since he was admitted. -She even tried to get him to take a sponge bath.	C 246		

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C 246	Continued From page 15 -Since admission, she was unable to get him to bathe or take a sponge bath. -She spoke with his Guardian about him not bathing and the Guardian had replied "that's just how he is." -She was not sure if he refused because it was a new environment or because he just did not want to take a bath. -She was unable to get Resident #1 to cut his toenails. -She did not know when Resident #1's toenails had last been trimmed. -The resident would tell her he would take a shower "but he just won't do it." -The resident's toenails "were so long now" she was afraid to cut them herself. -She thought he needed to be seen by a podiatrist. Interview with the SIC on 06/17/21 at 11:55am revealed: -It was her understanding, Resident #1 cared for his own beard. -She did not "even know" if Resident #1 had his own teeth. -"That's how little" she knew about the resident. -She had seen the resident go in the bathroom "twice" and the resident took a washcloth to "wash himself off." -She agreed the resident had not been getting personal care as he was supposed to get according to his care plan. Interview with the SIC on 06/17/21 at 2:05pm revealed: -She spoke with Resident #1's PCP on 05/10/21. -She did not tell the PCP about the issues she was having in providing personal care assistance to Resident #1 during the telephone conversation on 05/10/21.	C 246		

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C 246	Continued From page 16 -She noticed the length and condition of Resident #1's toenails "three weeks 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 05/18/21. -The PCP also spoke with facility staff via teleconference on 05/18/21. -The PCP did not know Resident #1 had not taken a bath since admission on 03/26/21. -The 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 day. -There 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 daily. -There 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. 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.	C 246		

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C 246	Continued From page 17 -Resident #1 was out of/or had not been taking apixaban, Digoxin, and 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 05/31/21. -The Digoxin was documented as not administered for 10 occurrences from 05/01/21 to 05/31/21. -The diltiazem was documented as not administered for 14 occurrences from 05/01/21 to 05/31/21. Review of Resident #1's June 2021 eMAR revealed the Combivent was documented as not administered for 2 occurrences from 06/01/21 to 06/16/21. Interview with the Supervisor-In-Charge (SIC) on 06/18/21 at 10:40am and 11:37am revealed: -Resident #1 had run out of several medications in April 2021. -She had contacted the contracted facility pharmacy to request refills of Resident #1's medications. -She waited on the refills to arrive from the contracted facility pharmacy before calling the pharmacy because she "assumed" the contracted pharmacy was having a "hard time" getting the medications. -She "usually" would call the pharmacy after she had "reordered" the medication "three or four	C 246		

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C 246	Continued From page 18 times." -She was informed Resident #1 did not get his medications from the contracted facility pharmacy, but from another pharmacy instead. -She had then contacted the resident's pharmacy to request refills. -She did not remember the exact date she had spoken with the resident's pharmacy. -When a medication was not available to administer, it was the facility's policy to contact the pharmacy to request a refill of the medication and get the medication "here." -It was the facility's policy to contact the resident's PCP "at the first missed dose" of a medication, however she did not contact Resident #1's PCP because she did not "think about it." Attempted telephone interview with Resident #1's Primary Care Physician (PCP) on 06/18/21 at 2:12pm was unsuccessful.	C 246		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure resident rights were maintained for 1 of 3 residents sampled (Resident #3) for not paying the resident in a timely manner for work completed at the facility. The finding are: Review of Resident #3's FL2 dated 04/23/21	C 311		

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C 311	Continued From page 19	C 311		

revealed diagnoses included traumatic brain injury and personality disorder.

Review of Resident #3's Resident Register revealed:
-The resident was admitted on 03/16/00.
-The resident had a guardian.

Review of Resident #3's Care Plan dated 04/23/21 revealed he required supervision with 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 years.
-He performed work around the facility for pay.
-He 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 work.
-It had been "awhile" since he had been paid for his work.
-He did not remember how much money he received for his work the last time he was paid.
-He did not know how much he was routinely paid for each of the tasks he performed at the facility.

Interview with the Supervisor-In-Charge (SIC) on 06/16/21 a 9:15am revealed:
-The transport staff had been on leave "for a month."
-She did not know when the transport staff would

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C 311	Continued From page 20 return from leave. Interview with the SIC on 06/17/21 at 9:05am revealed: -Resident #3 performed "yard work" at the facility. -The resident routinely cut the grass. -The resident used a weedeater in the flower beds outside the facility. -The resident fed and watered the ducks kept in a pen behind the sister facility next door. -The resident took out the trash in the sister facility next door "everyday." -"He takes the trash out for a cup of coffee." -She thought the transport staff paid Resident #3 for the work he performed. -She thought Resident #3 had "signed papers" saying it was something he wanted to do. -Resident #3 was an outside person and he enjoyed being outside. Review of a handwritten undated note revealed: -Resident #3 wanted to help around the property of the facility and no one forced the resident to do anything against his "will." -The note was signed by the resident, the Administrator, and an SIC from a sister facility. Interview with Resident #3 on 06/17/21 at 10:05am revealed: -He signed a paper "awhile" ago. -He did not remember when he signed it. -He wanted to work around the facility, but he wanted to get paid for his work. -He remembered he was paid for his work in April 2021, however he could not remember how much. Telephone interview with the Administrator on 06/17/21 at 1:45pm revealed: -Resident #3 was paid for the tasks he completed	C 311		

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C 311	Continued From page 21 around the facility on the day he completed the tasks. -He was last paid $20 "about two weeks ago" for weedeating for 30 minutes around the facility. -The resident "always" got paid regardless of the task. -The resident was paid $10 for sweeping the porches and sidewalks. -The resident was paid $20 for mowing the grass. -Resident #3 would request chores to do.	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1) related to medications used to treat atrial fibrillation, high blood pressure, prevent blood clots, wheezing and shortness of breath. The findings are:	C 330		

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C 330	Continued From page 22 Review of Resident #1's current FL2 dated 10/19/20 revealed diagnoses included renal failure and iliac artery aneurysm. Interview with the Supervisor-In-Charge (SIC) on 06/16/21 at 1:10pm revealed 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 twice daily from 05/10/21 at 8:00pm to 05/31/21 at 8:00pm.	C 330		

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C 330	Continued From page 23 -The apixaban was documented as not administered 05/01/21 at 8:00am to 05/10/21 at 8:00am due to "waiting on medication-pharmacy notified." -The apixaban was documented as not administered for 16 occurrences from 05/01/21 to 05/31/21. Observation of Resident #1's medications on hand on 06/18/21 at 10:45am revealed: -There was one open bottle of apixaban 5mg tablets. -There were 53 and one-half tablets remaining in the open bottle which originally contained 60 tablets dispensed on 05/11/21. -The label directions were apixaban 5mg 1 tablet twice a day. -There were three unopened bottles with label directions to administer apixaban 5mg 1 tablet twice daily. -One bottle contained 60 tablets of 180 tablets dispensed on 01/07/21. -The second and third bottles contained 60 tablets each of 180 tablets and were dispensed on 05/11/21. Interview with the Supervisor-In-Charge (SIC) on 06/18/21 at 10:40am and 11:37am revealed: -She had administered apixaban 5mg 1 tablet twice a day to Resident #1 with the exception of the end of April 2021 and first of May 2021, when she documented the medication as not administered on the eMARs. -Resident #1 ran out of several medications in April 2021. -She never saw the unopened bottle of apixaban filled 01/07/21. -She contacted the contracted facility pharmacy to request refills of Resident #1's medications. -She waited on the refills to arrive from the	C 330		

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contracted facility pharmacy before calling the pharmacy because she "assumed" the contracted pharmacy was having difficulty getting the medications.
-She was informed Resident #1 did not get his medications from the contracted facility pharmacy, but from another pharmacy instead.
-She then contacted the resident's pharmacy to request a refill.
-She did not remember the exact date she spoke with the resident's pharmacy.
-She received several refill bottles of apixaban "several days" after she spoke with Resident #1's pharmacy.
-When a medication was not available to administer, it was the facility's policy to contact the pharmacy to request a refill of the medication.

Attempted telephone interview with Resident #1's PCP on 06/17/21 at 9:13am and 06/18/21 at 2:12pm was unsuccessful.

Attempted telephone interview with Resident #1's pharmacy on 06/18/21 at 2:31pm was unsuccessful.

Refer to the review of Resident #1's note to Primary Care Provider (PCP) dated 04/26/21 at 3:37pm.

Refer to the review of Resident #1's Primary Care Provider (PCP) note dated 04/27/21 at 3:15pm.

Refer to the review of Resident #1's addendum progress note pharmacist entry dated 05/03/21.

Refer to the review of Resident #1's Pharmacy Telephone Encounter Note dated 05/10/21 at 8:52am.

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C 330	Continued From page 25 b. Review of Resident #1's physician order dated 03/26/21 revealed Combivent take 2 inhalations four times a day. Review of Resident #1's March 2021 electronic Medication Administration Record (eMAR) revealed: -There was no entry for Combivent. -There were no documented 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 8:00pm. -The Combivent was documented as not administered from 04/02/21 at 4:00pm to 04/22/21 at 8:00am due to "waiting on medication-pharmacy notified." -The Combivent was documented as not administered for 75 occurrences from 04/02/21 to 04/30/21. Review of Resident #1's June 2021 eMAR revealed: -There was an entry for Combivent inhale 2 puffs four times daily scheduled for 8:00am, 12:00pm, 4:00pm, and 8:00pm. -The Combivent was documented as administered from 06/01/21 to 06/16/21 at 8:00am. -The Combivent was documented as not administered on 06/16/21 at 12:00pm and on 06/16/21 at 8:26pm due to "waiting on medication-pharmacy notified." -The Combivent was documented as not administered for 2 occurrences from 06/01/21 to 06/17/21.	C 330		

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C 330	Continued From page 26 Observation of Resident #1's available Combivent on 06/16/21 at 11:31am revealed: -There were no actuations remaining in the inhaler. -The inhaler contained 120 metered doses and was dispensed on 04/19/21. Interview with the Supervisor-In-Charge (SIC) on 06/16/21 at 11:32am revealed: -Resident #1 took "his last dose" of the Combivent "this morning." -"I need to reorder it." Interview with the SIC on 06/16/21 at 1:10pm revealed she could get the Combivent inhaler for Resident #1 through the facility's contracted pharmacy, but it was "so expensive" because the resident did not have insurance. Interview with the SIC on 06/16/21 at 3:15pm revealed: -She ordered the Combivent from the facility's contracted pharmacy on 06/16/21. -They would deliver the medication to the facility that evening. -The resident received the Combivent as scheduled "except at lunch today." Telephone interview with Resident #1's pharmacy on 06/17/21 at 1:00pm revealed: -The current order for the Combivent was 2 puffs four times a day. -They last dispensed a Combivent inhaler on 05/11/21. -There were 120 actuations in one Combivent inhaler which provided a 30 day supply with the current order. -The Combivent should have been reordered from the pharmacy every 30 days. -The Combivent had to be reordered as it was not	C 330		

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on automatic refill.
-The Combivent should have been refilled every 30 days through their telephone reordering system.

Interview with the SIC on 06/18/21 at 10:40am revealed:
-Resident #1 was out of Combivent for quite awhile in April 2021, but he had his albuterol (used to treat shortness of breath) inhaler.
-The pharmacist from Resident #1's pharmacy told her how to get refills on medications through the pharmacy's telephone reordering system.
-She did not know how to reorder Resident #1's medications until she spoke with the pharmacist from Resident #1's pharmacy (05/10/21).

Interview with the SIC on 06/18/21 at 11:37am revealed when a medication was not available to administer, it was the facility's policy to contact the pharmacy to request a refill of the medication.

Attempted telephone interview with Resident #1's PCP on 06/17/21 at 9:13am and 06/18/21 at 2:12pm was unsuccessful.

Refer to the review of Resident #1's note to Primary Care Provider (PCP) dated 04/26/21 at 3:37pm.

Refer to the review of Resident #1's Primary Care Provider (PCP) note dated 04/27/21 at 3:15pm.

Refer to the review of Resident #1's addendum progress note pharmacist entry dated 05/03/21.

Refer to the review of Resident #1's Pharmacy Telephone Encounter Note dated 05/10/21 at 8:52am.

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C 330	Continued From page 28 c. Review of Resident #1's physician order dated 01/18/21 revealed Digoxin (used to treat atrial fibrillation) 250mcg take one half tablet daily. Review of Resident #1's April 2021 eMAR revealed: -There was an entry for Digoxin 250mcg 1 tablet every day scheduled at 8:00am. -The Digoxin was documented as administered 04/01/21 to 04/27/21 and on 04/29/21. -The Digoxin was documented as not administered on 04/28/21 and 04/30/21 due to "waiting on medication-pharmacy notified." -The Digoxin was documented as not administered for 2 occurrences from 04/01/21 to 04/30/21. 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 Digoxin. Review of Resident #1's May 2021 eMAR revealed: -There was an entry for Digoxin 250mcg 1 tablet every day scheduled at 8:00am. -The Digoxin was documented as administered 05/11/21 to 05/31/21. -The Digoxin was documented as not administered from 05/01/21 to 05/10/21 due to "waiting on medication-pharmacy notified." -The Digoxin was documented as not administered for 10 occurrences from 05/01/21 to 05/31/21. Observation of Resident #1's available Digoxin on 06/16/21 at 11:28am revealed: -There was one bottle of Digoxin 250mcg with label directions to take one-half tablet daily.	C 330		

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C 330	Continued From page 29 -There were 45 tablets dispensed on 05/11/21 with 44 whole tablets and 8 half tablets available in the bottle. Telephone interview with the facility's contracted pharmacy on 06/16/21 at 1:02pm revealed: -They provided the eMARs for the facility. -The last order they had for Resident #1's Digoxin 250mcg 1 tablet everyday dated 02/12/20. -The order was used for the entry on Resident #1's eMAR. -They did not supply Digoxin for Resident #1. Telephone interview with Resident #1's pharmacy on 06/17/21 at 1:17pm revealed: -The pharmacy dispensed Digoxin 250mcg 45 tablets on 02/20/21 and 05/11/21. -A 45 tablet refill should be a 90 day supply. Interview with the Supervisor-In-Charge (SIC) on 06/18/21 at 11:37am revealed when a medication was not available to administer, it was the facility's policy to contact the pharmacy to request a refill of the medication. Interview with the SIC on 06/18/21 at 2:00pm revealed: -She was following the directions on the bottle of the Digoxin instead of the eMAR. -She administered one-half tablet of Digoxin 250mcg to Resident #1 as per the bottle label directions. Attempted telephone interview with Resident #1's PCP on 06/17/21 at 9:13am and 06/18/21 at 2:12pm was unsuccessful. Refer to the review of Resident #1's note to Primary Care Provider (PCP) dated 04/26/21 at 3:37pm.	C 330		

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C 330	Continued From page 30 Refer to the review of Resident #1's Primary Care Provider (PCP) note dated 04/27/21 at 3:15pm. Refer to the review of Resident #1's addendum progress note pharmacist entry dated 05/03/21. Refer to the review of Resident #1's Pharmacy Telephone Encounter Note dated 05/10/21 at 8:52am. d. Review of Resident #1's physician order dated 01/18/21 revealed diltiazem (used to treat high blood pressure) 180mg 24 hr. capsule take 1 capsule daily. 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. 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 diltiazem. Review of Resident #1's May 2021 eMAR revealed: -There was an entry for diltiazem CD 180mg 1 capsule daily scheduled at 8:00am. -The diltiazem was documented as administered	C 330		

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from 05/15/21 to 05/31/21.
-The diltiazem was documented as not administered 05/01/21 to 05/14/21 due to "waiting on medication-pharmacy notified."
-The diltiazem was documented as not administered for 14 occurrences from 05/01/21 to 05/31/21.

Observation of Resident #1's available diltiazem on 06/16/21 at 11:50am revealed:
-There was one bottle of diltiazem CD 180mg capsules with label directions to take one tablet daily.
-There were 90 capsules dispensed on 05/11/21 with 66 capsules available in the bottle.

Interview with the Supervisor-In-Charge (SIC) on 06/18/21 at 10:40am and 11:37am revealed:
-Resident #1 ran out of several medications in April 2021.
-She never saw the unopened bottle of apixaban filled 01/07/21.
-She contacted the contracted facility pharmacy to request refills of Resident #1's medications.
-She waited on the refills to arrive from the contracted facility pharmacy before calling the pharmacy because she assumed the contracted pharmacy was having difficulty getting the medications.
-She was informed Resident #1 did not get his medications from the contracted facility pharmacy, but from another pharmacy instead.
-She then contacted the resident's pharmacy to request a refill.
-She did not remember the exact date she spoke with the resident's pharmacy.
-When a medication was not available to administer, it was the facility's policy to contact the pharmacy to request a refill of the medication.

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C 330	Continued From page 32 Attempted telephone interview with Resident #1's PCP on 06/17/21 at 9:13am and 06/18/21 at 2:12pm was unsuccessful. Refer to the review of Resident #1's note to Primary Care Provider (PCP) dated 04/26/21 at 3:37pm. Refer to the review of Resident #1's Primary Care Provider (PCP) note dated 04/27/21 at 3:15pm. Refer to the review of Resident #1's addendum progress note pharmacist entry dated 05/03/21. Refer to the review of Resident #1's Pharmacy Telephone Encounter Note dated 05/10/21 at 8:52am. _____ Review of Resident #1's note to Primary Care Provider (PCP) dated 04/26/21 at 3:37pm revealed: -The pharmacy was unable to get in touch and determine the physician and medication refills for "two and a half months." -The pharmacist reported all medications needed renewals and refills. -The pharmacy could no longer authorize emergency refills. Review of Resident #1's PCP note dated 04/27/21 at 3:15pm revealed: -The PCP nurse spoke with the SIC. -The SIC reported Resident #1 received all his medications through the facility's contracted pharmacy. -The SIC and PCP's nurse reviewed all of the residents medications. -There was an addendum dated 05/01/21 per Resident #1's Primary Care Physician requesting the pharmacist and social worker work with the	C 330		

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resident's caregiver and "find out exactly what he should be taking" and compile an accurate list before the resident's upcoming appointment with the physician on 05/13/21.

Review of Resident #1's addendum progress note pharmacist entry dated 05/03/21 revealed:
-The pharmacist called and sent a letter on 04/27/21 to review Resident #1' medications.
-The pharmacist had not been able to "connect" with Resident #1 as of 05/03/21.

Review of Resident #1's Pharmacy Telephone Encounter Note dated 05/10/21 at 8:52am revealed:
-The resident was referred to the medication admission prevention telephone clinic at the local veterans administration medical clinic by the resident's primary care physician given medication confusion and not taking many pertinent medications as prescribed.
-The pharmacist who made the telephone encounter note spoke with facility staff.
-The caregiver would like to come pick up refills of medications to avoid them getting lost in mail in the future.

_____

The facility failed to administer the following medications as ordered: 12 doses of Digoxin to treat atrial fibrillation, 16 doses of diltiazem to treat high blood pressure, 18 doses of apixaban to prevent blood clots, and 77 doses of Combivent to treat wheezing and shortness of breath during April 2021, May 2021, and June 2021 because the medications were not reordered. These failures caused a substantial risk of serious neglect and constitutes a Type A2 Violation.

_____

The facility provided a plan of protection in

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C 330	Continued From page 34 accordance with G.S. 131D-34 on 06/16/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 22, 2021.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (Resident #1).	C 342		

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C 342	Continued From page 35 The findings are: Review of Resident #1's current FL2 dated 10/19/20 revealed diagnoses included renal failure and iliac artery aneurysm. 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. Review of Resident #1's April 2021 eMAR revealed: -There was an entry for Digoxin 250mcg 1 tablet every day scheduled at 8:00am. -The Digoxin was documented as administered 04/01/21 to 04/27/21 and on 04/29/21. -The Digoxin was documented as not administered on 04/28/21 and 04/30/21 due to "waiting on medication-pharmacy notified." -The Digoxin was documented as not administered for 2 occurrences from 04/01/21 to 04/30/21. 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 Digoxin.	C 342		

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C 342	Continued From page 36 Review of Resident #1's May 2021 eMAR revealed: -There was an entry for Digoxin 250mcg 1 tablet every day scheduled at 8:00am. -The Digoxin was documented as administered 05/11/21 to 05/31/21. -The Digoxin was documented as not administered from 05/01/21 to 05/10/21 due to "waiting on medication-pharmacy notified." -The Digoxin was documented as not administered for 10 occurrences from 05/01/21 to 05/31/21. Observation of Resident #1's available Digoxin on 06/16/21 at 11:28am revealed: -There was one bottle of Digoxin 250mcg with label directions to take one-half tablet daily. -There were 45 tablets dispensed on 05/11/21 with 44 whole tablets and 8 half tablets available in the bottle. Telephone interview with the facility's contracted pharmacy on 06/16/21 at 1:02pm revealed: -They provided the eMARs for the facility. -The last order they had for Resident #1's Digoxin 250mcg 1 tablet everyday dated 02/12/20. -The order was used for the entry on Resident #1's eMAR. -They did not supply Digoxin for Resident #1. Telephone interview with Resident #1's pharmacy on 06/17/21 at 1:17pm revealed: -The current order for Digoxin 250mcg one-half tablet daily dated 05/11/21. -The prior order was for Digoxin 250mcg one-half tablet daily dated 02/20/21. -The pharmacy had dispensed Digoxin 250mcg 45 tablets on 02/20/21 and 05/11/21. -A 45 tablet refill should be a 90 day supply.	C 342		

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C 342	Continued From page 37 Interview with the Supervisor-In-Charge (SIC) on 06/17/21 at 2:00pm revealed: -She was following the directions on the bottle of the Digoxin instead of the eMAR, because "sometimes" the eMARs were "wrong". -She was administering one-half tablet of Digoxin 250mcg daily to Resident #1 as per the bottle label directions. Interview with the SIC on 06/18/21 at 11:37am revealed: -It was her responsibility to fax new or change orders to the contracted facility pharmacy, so they could update the eMAR. -She noticed the bottle directions did for the Digoxin did not match the eMAR , but she administered the Digoxin by the label directions. -She noticed the label and the eMAR were different, but she did not "follow through" with the contracted facility pharmacy to find out why the orders were different. 2. Review of Resident #1's physician's order dated 03/26/21 revealed metoprolol (used to treat high blood pressure) 50mg twice daily. Review of Resident #1's April 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for metoprolol ER 100mg 1 tablet every day scheduled at 8:00am. -The metoprolol ER 100mg was documented as administered 04/01/21 to 04/26/21 at 8:00am daily. -The metoprolol ER 100mg was documented as discontinued on 04/27/21. -There was an entry for metoprolol ER 100mg take 1/2 tablet at bedtime scheduled at 8:00pm. -The metoprolol ER 100mg take 1/2 tablet at bedtime was documented as administered daily	C 342		

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C 342	Continued From page 38 at 8:00pm from 04/01/21 to 04/26/21. -The metoprolol ER 100mg take 1/2 tablet at bedtime was discontinued on 04/27/21. -There was an entry for metoprolol 50mg 1 tablet twice a day scheduled at 8:00am and 8:00pm. -The metoprolol 50mg 1 tablet was documented as administered 04/01/21 to 04/30/21 at 8:00am and 8:00pm. Observation of Resident #1's medications on hand on 06/16/21 at 11:15am revealed: -There was one bubble pack of 50mg tablets with one tablet remaining out of 31 tablets dispensed on 05/05/21. -There was a second bubble pack of metoprolol 50mg tablets with 30 tablets dispensed on 06/07/21. -There was a third bubble pack of metoprolol 50mg tablets with 30 tablets dispensed on 06/07/21. -The label directions on all three bubble packs were metoprolol 50mg take one tablet twice daily. Observation of Resident #1's medications on hand on 06/18/21 at 11:05am revealed: -There was one bottle of metoprolol 100mg tablets. -The label directions were metoprolol 100mg take one-half a tablet every 12 hours. -There were 89 remaining tablets of a bottle of 90 tablets. -The dispense date was 05/11/21. Interview with the Supervisor-In-Charge (SIC) on 06/18/21 at 11:37am revealed: -When Resident #1 was first admitted the metoprolol order was to administer 100mg a day. -Then the order had changed to metoprolol 50mg two times a day. -She gave the metoprolol as per the label	C 342		

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FAIRVIEW FAMILY CARE HOME # 2	256 GRAVELY BRANCH ROAD FLETCHER, NC 28732

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 39 directions. -On the April eMAR, the metoprolol ER 100mg documented as administered 04/01/21 to 04/26/21 daily at 8:00am was a documentation error. -On the April eMAR, the metoprolol ER 100mg take 1/2 tablet at bedtime documented as administered daily at 8:00pm from 04/01/21 to 04/26/21 was a documentation error. -Resident #1 had received metoprolol 50mg twice daily as ordered since 04/01/21. -It was her responsibility to fax new or change orders to the contracted facility pharmacy, so they could update the eMAR.	C 342		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 612	Continued From page 40 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained during the global Coronavirus (COVID-19) pandemic to provide protection to the residents and to reduce the risk of transmission and infection as related to the facility not taking resident or staff temperatures or screening for COVID-19 symptoms. The findings are: Review of the CDC guideline dated 03/29/21 for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed: -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Actively monitor all residents at least daily for fever and symptoms consistent with COVID-19. -Staff should wear a facemask at all times while they were in the facility. Review of the NC DHHS guidelines dated 05/05/21 for the prevention and spread of the Coronavirus Disease in LTC facilities revealed: -Recommended routine infection prevention control (IPC) practices during the COVID-19 pandemic include screening everyone entering a	C 612		

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C 612	Continued From page 41 healthcare facility for signs and symptom of COVID-19 by temperature checks, screening questions, and observations of signs and symptoms. Interview with a resident on 06/16/21 at 8:42am revealed facility staff did not screen him daily for symptoms of COVID-19. Interview with a second resident on 06/16/21 at 8:54am revealed COVID-19 screening was done on residents at the beginning of the pandemic but was discontinued about 2 months ago after the residents had their vaccines. Interview with the Supervisor in Charge (SIC) on 06/17/21 at 9:24am revealed: -All residents had their vaccines but "only one" staff, that lived at the facility, had taken the vaccine. -She screened the residents for COVID-19 by taking their temperature and asking them questions "maybe" 1-2 times a week. -She changed the screening from daily to 1-2 times a week after the residents received their vaccines. -She completed a screening log on live-in staff "for a while" but stopped after the vaccines were completed. -She had a "COVID book" but did not know where the facility's infection control policy was. -She "thought" the infection control policy was at a sister facility but would need to check. Review of the Infection Control policy was unsuccessful because it could not be located. Interview with the Administrator on 06/17/21 at 12:37pm revealed she did not know where the infection control policy would be located.	C 612		

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C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: 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.[Refer to Tag 0242, 10A NCAC 13G .0901(a) Personal Care and Supervision (Type A2 Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free of neglect related to medication administration. The findings are:	C 914		

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C 914	Continued From page 43 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1) related to medications used to treat atrial fibrillation, high blood pressure, prevent blood clots, wheezing and shortness of breath.[Refer to Tag 0330, 10A NCAC 13G .1004(a) Medication Administration (Type A2 Violation)].	C 914		