STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				A. BUILDING:	
		FCL001107	B. WING		R 05/03/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	
MOHED E	AMILY CARE	206 FRI	ENDLY ROAD		
WIOHER	AWILT CARE	BURLIN	IGTON, NC 27216		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{C 000}	Initial Comments		{C 000}		
	The Adult Care Licens follow-up survey on 0	sure Section conducted a 5/03/19.			
{C 147}	10A NCAC 13G .0406 Qualifications	S(a)(7) Other Staff	{C 147}		
		Other Staff Qualifications of a family care home			
	(7) have a criminal baccordance with G.S. 131D-40;	_			
	-				
	The findings are:				
	Review of the Administrevealed: -He was hired on 07/0 -There was no docum				
	background check ha	d been completed. ninistrator on 05/03/19 at			
	1:10pm revealed: -A criminal backgroun	d check had been			
	required for facility sta	ckground checks were aff.			
	<ul><li>-He was responsible the background checks.</li><li>-He was responsible the realized his criminal</li></ul>	-			
	not in his employee fil				

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

(X6) DATE TITLE

DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION (X3) DATE		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
						,
		FOI 004407	B. WING		F	
		FCL001107	D: Wii(0		05/0	3/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
		206 FRIE	NDLY ROAD			
MOHER F	AMILY CARE	BURLING	STON, NC 27210	6		
0/0.15	STIMMADV ST.			PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
{C 147}	Continued From page	<u>.</u> 1	{C 147}			
(0 )	. •		[(0,117)			
	2019 to complete the	background check.				
	Talanhana intensiaww					
	05/03/19 at 1:12pm re	vith the bail bondsman on				
	-The Administrator ha					
	completing a backgro					
		d her two weeks ago about				
	the background check	_				
	-She had not had time					
	background check.	- 10 0011 p. 1010				
	-	lled her today, 05/03/19				
	about the background					
	-When she talked to h					
	05/03/19, he told her	•				
	requested backgroun					
		ne Administrator to tell him				
	she could not comple	te the background check.				
C 246	10A NCAC 13G .0902	2(b) Health Care	C 246			
	10A NCAC 13G .0902	2 Health Care				
		assure referral and follow-up				
	· ·	nd acute health care needs				
	of residents.					
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION					
		ns, interviews, and record				
	reviews, the facility fa					
		esident #3) a diabetic				
		eferral for an endocrinologist				
		ered by the primary care				
	provider (PCP).					
	The findings are:					
	Review of Resident #	3's current FL-2 dated				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 2 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		, , ,	E SURVEY PLETED	
		FCL001107	B. WING	B. WING		R 5/ <b>03/2019</b>
	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	E, ZIP CODE		
	7.111.21 07.11.2	BURLIN	GTON, NC 27216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 246	11/28/18 revealed dia diabetes, anemia, bip failure, hyperlipidemia pulmonary disease (C disorder, essential hy disease, and schizoa 1. Review of an appo dated 04/17/19 revea appointment with an extended of the contrologist office revealed:  -Resident #3 had an an of the contrologist of the crevealed: -Resident #3 had an an of the contrologist of the care of the contrologist of the c	agnoses included type 2 colar, hypertension, kidney a, chronic obstructive COPD), major depressive repertension, cardiovascular ffective disorder.  intment card for Resident #3 fled Resident #3 had an endocrinologist at 1:30pm.  with a representative at the on 05/03/19 at 11:54am  appointment scheduled for t was documented he was a  appointment was raff. erred to the endocrinologist Provider (PCP).  with a physician who was t #3 on 05/03/19 at 11:55am  betic and was referred to the use his diabetes was not ent regimen. Resident #3 did not see the  ministrator on 05/03/19 at  neduled to go the use his A1C was high. (An est that reflects your average over the past 3 months. An	C 246			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 3 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
		FCL001107	B. WING		05/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		206 FRIEN	IDLY ROAD			
MOHER F	AMILY CARE	BURLING <sup>*</sup>	TON, NC 27216	6		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
C 246	Continued From page	e 3	C 246			
	-The PCP had chang medication several tir -Resident #3 ate thing eat and that was why highResident #3 refused on 01/10/19 and on 0-He had documented to the appointment or Interview with Reside revealed: -He went to the doctor-He had never refuse-His regular doctor moderate the had not seen a sequence of the second of the had not seen a sequence of the had not s	ed Resident #3's diabetic mes. gs he was not supposed to Resident #3's A1C was to go to the endocrinologist 4/17/19. Resident #3 refused to go no 04/17/19. ent #3 on 05/03/19 at 2:03pm or all the time. d to go to the doctor. anaged his diabetes. pecialist for his diabetes. ten note signed by the ted 05/17/19 revealed				
	and will be reschedul					
	05/03/19 at 1:56pm re-She was very conce to the endocrinologist -She had referred Re endocrinologist becaus Resident #3's A1C haracterist -Resident #3 was on diabetic medication a	rned Resident #3 did not go t. sident #3 to the use she was concerned ad increased. both an injection and oral nd his A1C had increased; but on managing Resident				
	-Resident #3's A1C w on 04/18/19. -When she had a res not being controlled s an endocrinologist.	e endocrinologist.  vas 9.4 on 01/17/19 and 9.9  ident whose diabetes was the referred that resident to cility staff to see to it that				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 4 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMI LETED
		FCL001107	B. WING		R 05/03/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MOUEDE	AMILY CARE	206 FRIEN	DLY ROAD		
WOHER	AWILT CARE	BURLINGT	ON, NC 27216	3	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 246	Continued From page	e 4	C 246		
	Resident #3 went to to order.	he endocrinologist per her			
	-	Care Provider's (PCP) note led an order for Resident #3 diabetic foot care.			
	1:00pm revealed: -He did not make app the PCP's office staff appointmentsHe had not received Resident #3 to go to t -He had not followed PCP that Resident #3 Telephone interview v	an appointment for the podiatrist. up on the note from the needed to see a podiatrist. with Resident #3's PCP on			
	05/03/19 at 1:56pm revealed: -All diabetic residents need to see a podiatristShe expected Resident #3 to see a podiatrist when the referral was madeResident #3 needed to be scheduled to see a podiatrist.				
	revealed: -He had not been to a -His toenails did not n -He did not want to ta	need cutting.			
	2:47pm revealed: -A referral was made 11/28/18; the referral office.	vith an administrative soffice on 05/03/19 at to a named podiatrist on was faxed to the podiatrist's up to see if an appointment			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 5 of 33

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.25 10.	A. BUILDING.		
		FCL001107	D 14/11/0		R <b>05/03/2019</b>	)
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHER F	AMILY CARE	206 FRIEN				
BURLING			ON, NC 27216			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMP	PLETE
C 246	Continued From page	5	C 246			
	-	not requested an ay 05/03/19.  with a representative at the				
	podiatrist's office on 0 revealed: -Resident #3 did not h	·				
	-Resident #3 did not have an appointment to see the podiatristThey received referrals by fax from Resident					
	#3's PCPShe did not see a referral for Resident #3 to see the podiatrist.					
	The facility failed to assure referral and follow-up 1 of 3 sampled residents (#3) who missed two endocrinology appointments who had a history of diabetes and an elevated A1C; and did not follow-up with Resident #3's PCP related to a podiatry referral five months after the PCP had made the recommendation. The facility's failure was detrimental to the health and safety of the resident which constitutes a Type B Violation.					
	The facility provided a accordance with G. S this violation.	a plan of protection in . 131D-34 on 05/03/19 for				
	CORRECTION DATE VIOLATION SHALL N 2019.	FOR THE TYPE B IOT EXCEED JUNE 2,				
{C 249}	10A NCAC 13G .0902	2(c)(3)(4) Health Care	{C 249}			
	following in the reside (3) written procedure	assure documentation of the				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 6 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
FCL001107 B. WING 05/			05/03/2019		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MOHER F	AMILY CARE	206 FRIEN			
	OLUMBA DV OT		ON, NC 27216		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{C 249}	Continued From page	: 6	{C 249}		
		f procedures, treatments or bparagraph (c)(3) of this			
	This Rule is not met	as evidenced by:			
	reviews, the facility fa provider orders were	is, interviews, and record iled to assure primary care implemented for 2 of 3 and #3) related to finger SBS).			
	The findings are:				
	11/28/18 revealed dia diabetes, anemia, bip failure, hyperlipidemia pulmonary disease (C	COPD), major depressive pertension, cardiovascular			
		is FSBS today, 05/03/19. sometimes; staff took his			
	at 10:32am revealed: -There were no FSBS -There were results d of March, no results for year was not part of the control of th	ate stamped for the month or April, May and June. (The			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 7 of 33

Division of Health Service Regulation					1	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AIND PLAN	OI CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		CONFLETED	
					R	
		FCL001107	B. WING		05/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	F ZIP CODE		
TO THIS COLUMN	NOVIDEN ON OUT FEET		ENDLY ROAD	2,211 0002		
MOHER F	AMILY CARE		GTON, NC 27216			
	OLIMANA DV OT			PROVIDENIA DI ANI OF CORRECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
{C 249}	Continued From page	e 7	{C 249}			
	_	glucometer did not match n the MARs for February				
	revealed: -There was a comput FSBS twice daily sch 8:00pmResident #3's FSBS	e3's February 2019 ation Records (MARs) eer-generated entry to check eduled at 7:00am and were documented twice 2/28/19; ranges were				
	revealed: -There was a comput FSBS twice daily sch 8:00pmResident #3's FSBS	er-generated entry to check eduled at 7:00am and were documented twice 3/31/19; ranges were				
	FSBS twice daily sch 8:00pm. -Resident #3's FSBS	er-generated entry to check eduled at 7:00am and were documented twice 4/30/19; ranges were				
	FSBS twice daily sch 8:00pm.	ear-generated entry to check eduled at 7:00am and				

Division of Health Service Regulation

daily from 05/01/19-05/03/19; ranges were

STATE FORM 6899 D9V212 If continuation sheet 8 of 33

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		FCL001107	B. WING		R 05/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHER F	AMILY CARE	206 FRIEN BURLINGT	DLY ROAD ON, NC 27216	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{C 249}	(MA) on 05/03/19 at 1 -He took Resident #3 -He used the last test -He did not know why Resident #3's glucome FSBS recorded in the -If the date was wrong wrong tooHe did not know whe were "right off hand."  Telephone interview w facility's contracted pl 10:59am revealed: -A box of 50 glucome dispensed on 01/14/1 -There had been no of dispensed for Reside  Telephone interview w familiar with Resident revealed: -Resident #3 should it dailyIf Resident #3's FSB ordered he would not #3's diabetes was bei -He expected the faci #3's FSBS as ordered  Telephone interview w Care Provider (PCP) revealed: -She wanted Resident daily.	ministrator/medication aide 10:38am revealed: 2s FSBS twice daily. 3strip today, 05/03/19. 4 the FSBS results in 4 the FSBS results in 4 the readings must be 4 the June 2018 MARs  with the Pharmacist at the 4 harmacy on 05/03/19 at 4 the strips had been 9. 4 there glucometer strips 5 there glucometer strips 6 there glucometer strips 7 that a physician who was 8 that a physician who was 9 that a p	{C 249}			
	Resident #3's diabete	es was being managed.				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 9 of 33

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '		COMPLETED
			A. BUILDING: _	A. BUILDING:	
		FCL001107	B. WING		05/03/2019
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZIR CODE	
INAME OF T	NOVIDEN ON 3011 LIEN			TL, ZII GODE	
MOHER F	AMILY CARE		NDLY ROAD		
	T	BURLING	TON, NC 27216		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	( - /
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG		,	IAG	DEFICIENCY)	
(0.040)			(0.040)		
{C 249}	Continued From page	9	{C 249}		
	-The FSBS were impo	ortant so she could see if			
	Resident #3 was havi	ng "any dumps" because of			
	over-medicating; Res	ident #3 was taking oral			
	diabetes medication i	n addition to insulin.			
	-She was concerned	that Resident #3's A1C had			
	increased though his	FSBS did not support this.			
	(An A1C test is a bloc	od test that reflects your			
	average blood glucos	e levels over the past 3			
	months. An A1C level	below 5.7 percent is			
	considered normal).				
	-Resident #3's A1C w	as 9.4 on 01/17/19 and 9.9			
	on 04/18/19.				
		ow Resident #3's diabetes			
		f she did not have accurate			
	information.				
	,	rned Resident #3's FSBS			
	_	ed daily as ordered because			
	she could not effective	ely manage his diabetes.			
	Casand interview vide	the Administrator on			
	Second interview with				
	05/03/19 at 1:00pm re	was checked twice daily.			
		efused to check his FSBS.			
		how he was able to check			
	Resident #3's FSBS t				
		sed 50 glucometer strips on			
	01/14/19 and no addit				
	ordered.	aona carpo nad boon			
		nave purchased glucometer			
	strips over-the-counte				
		cometer strips could only be			
	purchased through th				
	physician' s order.				
	2. Review of Residen	t #1's current FL-2 dated			
	06/21/18 revealed:				
	-The diagnoses include	ded vascular dementia, type			
	two diabetes, cerebro	vascular accident old			
	infarct, history of seiz	ures, essential hypertension,			
	hyperlipidemia, tobac	co abuse and vitamin D3			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 10 of 33

DIVISION OF FIGURE REGulation				T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		ECI 004407	B. WING		1
		FCL001107			05/03/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		206 FRIE	NDLY ROAD		
MOHER F	AMILY CARE		TON, NC 27210	3	
	CLIMMA DV CT		<del></del>		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
{C 249}	Continued From page	<u> </u>	{C 249}		
(=,	. •	, 10	(0 = 10)		
	deficiency.				
		for FSBS checked daily,			
	before breakfast.				
	Design (D. 11 17	41a Faharran 2040			
	Review of Resident #				
		ation Records (MARs)			
	revealed:	an aranamata di antoni ta aba ali			
	FSBS daily before bre	er-generated entry to check			
	,				
	-Resident #1's FSBS were documented daily from 02/01/19-02/28/19; ranges were 100 to 113.				
	110111 02/01/19-02/20/	19, ranges were 100 to 113.			
	Review of Resident #	1's March 2019 MARs			
	revealed:	10 Maion 20 10 M/ (10			
		er-generated entry to check			
	FSBS daily before bre	-			
	-	were documented daily			
		19; ranges were 101 to 120.			
	Review of Resident #	1's April 2019 MARs			
	revealed:				
		er-generated entry to check			
	FSBS daily before bre				
		were documented daily			
	from 04/01/19-04/30/	19; ranges were 103 to 115.			
	Davious of Dasidant #	41a May 2010 MAD-			
	Review of Resident # revealed:	TS May ZUTS MAKS			
		er-generated entry to check			
	FSBS daily before bre				
		were documented daily			
		19; ranges were 107 to 110.			
	110111 0 <del>-1</del> /01/10-00/00/	10, ranges were for to fit.			
	Interview with Reside	nt #1 on 05/03/19 at 12:45			
	pm revealed:				
	•	nis FSBS today, 05/03/19.			
		once every three months;			
		k his FSBS "was sometime			
	in February".				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 11 of 33

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			_		_	
			B. WING		R	
		FCL001107	B. WING		05/0	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
				, 2		
MOHER FAMILY CARE						
	1	BUKLING	TON, NC 27216	5		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	TEOGETHORI S.C.	200 IDENTIFICATION OF COMPANION,	TAG	DEFICIENCY)	IIAI L	
			+			
{C 249}	Continued From page	e 11	{C 249}			
	Davious of Posidont #	11's alugameter on 05/03/10				
		t1's glucometer on 05/03/19				
	at 10:58 am revealed					
		S test strips available for				
	Resident #1.	05/04				
		recorded on 05/01 with a				
	time stamp of 9:40 pn					
		mented on 05/01/19 there				
	was a FSBS recorded					
		recorded on 03/14, there was				
		ere was a result of 283.				
		mented on 03/14/19; there				
	was a FSBS recorded					
		recorded on 02/07, there was				
	-	ere was a result of 320.				
	-The MAR was docum	mented on 02/07/19; there				
	was a FSBS recorded	d as 105.				
	-There was a FSBS re	ecorded on 06/28, there was				
	no time stamp and the	ere was a result of 225.				
	-There was no year ir	ncluded on the date				
	recorded on the gluco	ometer.				
	-There were fifteen re	esults without dates or time				
	stamps with result rar	nges from 90 to 322; there				
	was only one reading	recorded in the glucometer				ı
	that matched the MAF					
	Telephone interview v	with Resident #1's Physician				
	on 05/03/19 at 11:30	am revealed:				ı
	-Resident #1 was ord	lered to have his FSBS				ı
	checked daily.					ı
		ility staff to check Resident				ı
		d; Resident #1's FSBS was				
	being monitored with					
		·				
	Telephone interview v	with the Pharmacist at the				
		harmacy on 05/03/19 at				
	11:50 am revealed:					
	-A box of 50 glucome	eter strips had been				
	dispensed in June 20					
		other glucometer strips				
		ent #1 until today 05/03/19.				
	aloponoca for recolact	Tit ii i aritii today ooroor to.				

STATE FORM 6899 D9V212 If continuation sheet 12 of 33

Division	of Health Service Regu	lation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
						R
		FCL001107	B. WING		0.5	5/03/2019
			<b>_</b>		, ,	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	:, ZIP CODE		
MOHER F	AMILY CARE		NDLY ROAD			
		BURLING	GTON, NC 27216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{C 249}	Continued From page	e 12	{C 249}			
		e responsible for ordering ips from the pharmacy when				
	(MA) on 05/03/19 at an electric Herook Resident #1 Resident #1 never reversults were always of the used Resident #1 morning, 05/03/19. He could not rememore ordered test strips for Resident #1 had test admitted to the facility how many test strips. He did not know he let test strips from the properties of the many test strips. He did not know why the MARs for Resident #1 when the MAR. He had never set the #1's glucometer. He never used Resident the mother resident's FS residents' test strips. He could not find the thought they were in sure.	's FSBS every morning; fused a FSBS and his FSBS good. I's last test strip that  ber the last time he had Resident #1 because strips with him when he was y, but could not remember Resident #1 had. had to order Resident #1's harmacy; he thought he over the counter. y the glucometer results and hat #1 did not match, he was he documented results on e date or time on Resident dent #1's glucometer for des and he never shared  MARs for June 2018 and storage, but he was not				
	ordered for 2 of 2 dia The facility's failure to diabetic residents at i hyperglycemia and hy failure was detrimenta	omplete FSBS checks as betic residents sampled. check FSBS placed the risk for side effects of ypoglycemia. The facility's all to the health and satiety of onstitutes a Type B Violation				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 13 of 33

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		FCL001107	B. WING		05	R 5/ <b>03/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MOHER F	AMILY CARE		ENDLY ROAD GTON, NC 27216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{C 249}	Continued From pag	e 13	{C 249}			
	T -	a plan of protection in S. 131D-34 on 05/03/19 for				
	CORRECTION DATE VIOLATION SHALL I 2019.	E FOR THE TYPE B NOT EXCEED JUNE 2,				
C 330	10A NCAC 13G .100 Administration	4(a) Medication	C 330			
	(a) A family care hor preparation and adm prescription and non by staff are in accord (1) orders by a licens which are maintained	4 Medication Administration me shall assure that the inistration of medications, prescription and treatments lance with: sed prescribing practitioner d in the resident's record; and on and the facility's policies				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa medications as order residents (#1 and #3	ns, interviews, and record ailed to administer red for 2 of 3 sampled ) related to physician's nd Incruse Ellipta (#3) and				
	The findings are:					
	11/28/18 revealed dia diabetes, anemia, bip failure, hyperlipidemi	nt #3's current FL-2 dated agnoses included type 2 polar, hypertension, kidney a, chronic obstructive COPD), major depressive				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 14 of 33

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		SURVEY PLETED
			7.1. 56.125.1.16.			D
		FCL001107	B. WING		05	R 5/ <b>03/2019</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
MOHED E	AMILY CARE	206 FRIE	NDLY ROAD			
WIOTILIKT	AWIET CARE	BURLING	STON, NC 27216			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 330	Continued From page	: 14	C 330			
	disorder, essential hy disease, and schizoat	pertension, cardiovascular fective disorder.				
	revealed an order for	t #3's FL-2 dated 11/28/18 for Levemir 100U/ml inject evemir is a long-acting I high blood sugar).				
	May 2019 MARs reversible -There was a compute Levemir insulin inject 8:00pmThere was document					
	Observation of Reside hand on 05/03/19 at 9 - There was a plastic befor Levemir insulin peer - The bag contained o	ent #3's medications on 0:00am revealed: pag with a prescription label in dispensed on 02/25/19. ne Levemir insulin pen. pen had dosages remaining				
	facility pharmacy on 0 revealed: -Two Levemir pens w for Resident #3Two Levemir insulin 02/25/19 for Resident -Two Levemir insulin #3's dosage of 35 uni approximately 17 day -The computer docum	pens were dispensed on 01/14/19 pens were dispensed on #3. pens based on Resident ts daily would last s. pented two pens were billed dispensed; if four pens were				
	· ·	ased on Resident #3's				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 15 of 33

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		FCL001107	B. WING		05/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
MOHER F	AMILY CARE		NDLY ROAD			
			GTON, NC 27216			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	e 15	C 330			
	35 days.					
	9:51am revealed: -The pharmacy usual each time it was dispondent the pharmacy and the thought the pharmacy and the pharmacy	macy had dispensed four time the prescription was units of Levemir injected and #3 on 05/03/19 at in for his diabetes. In but had not had an months.				
	medicationsResident #3 had not injections.					
	-He did not know why	Resident #3's Levemir pen when it had not been filled				
	familiar with Resident revealed: -Resident #3 was dia insulin injection every -If Resident #3 did no prescribed, his diabet -Resident #3 was sta	at get his insulin injection as tes would not be controlled.  Arted on oral diabetes on to his insulin to better				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 16 of 33

DIVISION OF FIGURE 1	Regulation	_		
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
				R
	FCI 004407	B. WING		1
	FCL001107			05/03/2019
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
	206 FRIE	NDLY ROAD		
MOHER FAMILY CARE		STON, NC 2721	6	
0.100				
(>(.).5	RY STATEMENT OF DEFICIENCIES HENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	()
	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	
			DEFICIENCY)	
C 330 Continued From I	nago 16	C 330		
C 330 Continued From p	page 16	0 330		
Telephone intervi	ew with Resident #3's Primary			
Care Provider (P	CP) on 05/03/19 at 1:56pm			
revealed:				
-Resident #3 had	been prescribed Levemir insulin			
35 units daily to o	control his diabetes.			
-It appeared Resi	ident #3's diabetes was not			
	so she started him on oral			
diabetic medication	on on 02/05/19 and increased			
the dosage on 04	1/25/19.			
	1C was 9.4 in January 2019 and			
	9.9 in April 2019. (An A1C test is			
	reflects your average blood			
	er the past 3 months. An A1C			
1 9	ercent is considered normal).			
	o manage Resident #3's			
diabetes.	o manago ricolacini ne e			
	esident #3's Levemir insulin to			
be injected daily a				
Do injected daily t	ao ordorod.			
b. Review of Res	ident #3's FL-2 dated 11/28/18			
	r for Incruse Ellipta inhale			
	illy. (Incruse Ellipta is a			
	sed to treat COPD).			
S. S				
Review of Reside	ent #3's February 2019 through			
May 2019 MARs	,			
	nputer-generated entry for			
	naler inhale contents by mouth			
once daily for bre				
	mentation Incruse Ellipta inhaler			
	d at 8:00am daily from 02/01/19			
through 05/03/19				
u	•			
Observation of R	esident #3's medications on			
	at 9:00am revealed:			
	cruse Ellipta inhaler dispensed			
on 02/06/19.	oraco Empla ilitator dioportoca			
l l	nt on the Incruse Ellipta inhaler			
was 23.	c die merdee Empta iinidiei			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 17 of 33

Division (	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FOI 004407	B. WING		R
		FCL001107	3:		05/03/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		206 FRIEI	NDLY ROAD		
MOHER F	AMILY CARE		TON, NC 27216	i i	
040.15	QLIMMADV QT				N OVE
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	( - /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
C 330	Continued From page	17	C 330		
0 000					
		with a Pharmacist at the			
	facility pharmacy on 0	)5/03/19 at 10:59am			
	revealed:				
	T =	naler was dispensed on			
	02/06/19 for Resident				
	·	naler was considered a bulk			
		d need to be reordered			
	monthly by the facility				
		aler showed how many			
	doses were left to be				
		sed his Ellipta daily as			
	· ·	ave run out of medication in			
	early March 2019.				
		to the first of the Property and a			
		ministrator/medication aide			
	(MA) on 05/03/19 at 9				
		s Incruse Ellipta inhaler			
	every day.	Con transpar Ellipto inholor			
		out the Incruse Ellipta inhaler			
	every month.	the label on the boy was for			
	-He did not know wny 02/06/19.	the label on the box was for			
		why the current count on			
	the Incruse Ellipta inh	why the current count on			
		alei was 25.			
	Interview with Reside	ont #3 on 05/03/19 at			
	10:30am revealed:	11t #3 011 03/03/19 at			
	-He did not use his in	haler every day			
		approximately two times per			
	week.	approximately two times per			
		en he last used his inhaler;			
		nhaler this week, (week of			
	04/29/19).	, ,			
	-He thought he was b	reathing "just fine."			
		3 1			
	A second interview w	ith the Administrator/MA on			
	05/03/19 at 1:00pm re	evealed:			
	-He was the only MA				
	medications.				

Division of Health Service Regulation

-He could not think of a time when Resident #3

STATE FORM 6899 D9V212 If continuation sheet 18 of 33

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:			
		FCL001107	B. WING		R <b>05/03/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHEDE	AMILY CARE	206 FRIEN	DLY ROAD			
WORLK	AWILT CARE	BURLINGT	ON, NC 27216	<b>S</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	e 18	C 330			
	had refused his Incru	se Ellipta inhaler. rthe inhaler had doses				
	familiar with Resident revealed: -Resident #3 was pre because he had chro disease (COPD)Resident #3 needed every dayIf Resident #3 did no every day he was at r COPD. (Exacerbation worsening of COPD s	quantity and color of phlegm				
	Care Provider (PCP) revealed: -Resident #3 had bee inhaler because he had a proper and was at risk of deviated barrel chest occurs be chronically over inflatistays partially expanded open his airway passident #3 needed daily; she was concertified.	rolonged expiratory phase veloping a barrel chest. (A ecause the lungs are ed with air, so the rib cage led all the time.).  the Ellipta inhaler daily to				
	06/21/18 revealed dia dementia, type two di	t #1's current FL2 dated agnoses included vascular abetes, cerebrovascular istory of seizures disorder,				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 19 of 33

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING	A. BUILDING:	
		FCL001107	B. WING		R 05/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MOHER F	AMILY CARE		DLY ROAD		
		BURLING	TON, NC 27216	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 330	Continued From page	: 19	C 330		
	essential hypertensionabuse and vitamin D3	n, hyperlipidemia, tobacco deficiency.			
	order dated 10/20/18 Respimat 2.5/2.5 mcg breathing. [(Stiolto Re	1's subsequent physician's revealed an order for Stiolto g inhale two puffs daily for espimat is a maintenance ontrol chronic obstructive COPD)].			
	May 2019 MARs reversible.  -There was a compute Stiolto Respimat inhat daily for breathing at a strength of the strength of th	er-generated entry for le two puffs by mouth once 3:00 am. tation Stiolto Respimat red at 8:00 am daily from			
	hand on 05/03/19 at 9 -There was a Stiolto F dispense date of 02/0	Respimat inhaler with a 6/19. on the inhaler had a gauge fs available.			
	facility's contracted ph 11:55 am revealed: -There was a Stiolto F on 02/06/19 for Resid -The inhaler contained prime the inhaler once puffs a day for thirty of -If Resident #1 had us prescribed, it would hearly March 2019.	d enough medication to e and then administer two			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 20 of 33

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) DATE		
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		FCL001107	B. WING		R 05/03/2019	)
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MOHED E	AMILY CARE	206 FRIEN	IDLY ROAD			
MOHER	AWILI CARE	BURLING	TON, NC 27216	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPI	LETE
C 330	Continued From page	e 20	C 330			
		staff when it was empty.				
	ordered by the facility	stall when it was empty.				
	on 05/03/19 at 11:30 -Resident #1 had bee October 2018 and wa Respimat inhaler to c -The Physician expect Resident #1 to be adr Resident #1 should h day as ordered He was concerned f could become exacer the daily use of the in  Interview with Reside am revealed: -He had taken all his 05/03/19, and all his r not use an inhalerHe could not rememinhaler because "it ha	en diagnosed with COPD in as ordered the Stiolto ontrol his COPD. Steed all medication for ministered as ordered; ave used his inhaler every Resident #1's condition stated and worsen without haler.  Int #1 on 05/03/19 at 12:45 morning medication today, medication were pills; he did ber when he last used an				
	Interview with the Adr (MA) on 05/03/19 at 2 -Resident #1 used his every morningHe always watched I in the morning, but he indicator gauge for he remained in the inhaleHe did not know the counter indicated the availableHe could not remembed been dispensed; automatically sent the He did not know why	ministrator/medication aide 2:00 pm revealed: s Stiolto Respimat inhaler Resident #1 use the inhaler e never checked the count ow much medication er. inhaler was full and that the re were still sixty puffs ber the last time the inhaler he thought the pharmacy				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 21 of 33

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		URVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					_	
					R	
		FCL001107	B. WING	<del></del>	05/0	3/2019
NAME OF D	DOVIDED OD CURRUED	CTDEET A	DDRESS, CITY, STA	TE 7/D 00DE		
NAIVIE OF P	ROVIDER OR SUPPLIER		, ,	TE, ZIP CODE		
MOHER F	AMILY CARE		NDLY ROAD			
		BURLING	STON, NC 27216	•		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	٧	(X5)
PRÉFIX	•	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 IGIENCI)		
C 330	Continued From page	21	C 330			
	for Resident #1 to use	e the inhaler every day as				
	ordered.					
		nsure medications were				
	administered for 2 of	3 sampled residents (#1 and				
		physician which resulted in				
	insulin and an inhaler	not being administered				
	daily as ordered (#3)					
		hyperglycemia and two				
	residents who had a h	nistory of COPD (#1 and #3)				
	who did not receive their bronchodilator as					
	ordered which could e	exacerbate the residents				
	COPD. This failure wa	as detrimental to the health,				
	safety, and welfare of	the residents and				
	constitutes a Type B					
	<b>,</b> ,					
	The facility provided a	a plan of protection in				
		. 131D-34 on 05/03/19 for				
	this violation.	. 10.2 0.0.00,00,10.00				
	and violation.					
	CORRECTION DATE	FOR THE TYPE B				
		NOT EXCEED JUNE 2,				
	2019.	TOT EXOLED TOTAL 2,				
	2010.					
(0.040)	404 NOAO 400 400	AZS NA - P - C	(0.040)			
{C 342}	10A NCAC 13G .1004	4(j) Medication	{C 342}			
	Administration					
	404 1104 0 400 400					
		4 Medication Administration				
	• ,	dication administration				
		e accurate and include the				
	following:					
	(1) resident's name;					
	` '	cation or treatment order;				
	(3) strength and dosa					
	medication administe					
	(4) instructions for ad	ministering the medication				
	or treatment;					
	(5) reason or justification	tion for the administration of				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 22 of 33

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED	
		FCL001107	B. WING		R 05/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MOHER F	AMILY CARE		IDLY ROAD FON, NC 27216	<b>S</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	E
{C 342}	documenting the result (6) date and time of a (7) documentation of medications or treatmomission, including re (8) name or initials of the medication or treasignature equivalent the documented and main administration record. This Rule is not met Based on observation reviews, the facility farmedication administration and complete for 2 of and #3), including insugars (FSBS) (#1) and The findings are:  1. Review of Resident 11/28/18 revealed diabetes, anemia, bip failure, hyperlipidemia pulmonary disease (0 disorder, essential hydisease, and schizoata. Review of Residen revealed an order for units once daily. (Levused to control high the Review of Resident #May 2019 MARs revealed an omput.)	nents as needed (PRN) and alting effect on the resident; dministration; 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 nationed with the medication (MAR).  as evidenced by: as, interviews, and record alled to assure the ation records were accurate as residents sampled (#1 ulin (#3), finger stick blood and inhalers (#1 and #3).  It #3's current FL-2 dated agnoses included type 2 polar, hypertension, kidney as, chronic obstructive COPD), major depressive pertension, cardiovascular affective disorder.  It #3's FL-2 dated 11/28/18 Levemir 100U/ml inject 35 emir is a long-acting insulin blood sugar).  3's February 2019 through	{C 342}			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 23 of 33

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND I LAN	. John Lonon	SERVIN IO MICH HOWIDER.	A. BUILDING: _		
		FCL001107	B. WING		R 05/03/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MOHER F	AMILY CARE		DLY ROAD TON, NC 27216	•	
	CHMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N 0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
{C 342}	Continued From page	e 23	{C 342}		
		tation Levemir 35 units was om daily from 02/01/19			
	hand on 05/03/19 at 9 -There was a plastic b for Levemir insulin pe -There was one Leve	pag with a prescription label on dispensed on 02/25/19.			
		ministrator on 05/03/19 at ident #3 had 35 units of /.			
	Interview with Reside 10:30am revealed: -He did not take insul -He took insulin in the insulin injection in 3-4	in for his diabetes. e past but he had not had an			
	facility pharmacy on 0 revealed: -Two Levemir pens w and 02/25/19 for Resi-Two Levemir insulin #3's dosage of 35 uni approximately 17 day	ere dispensed on 01/14/19 ident #3. pens based on Resident its daily would last is. nented two pens were billed			
	A second interview wi Administrator/medica at 1:00pm revealed: -He documented on F administered the insu	ith the tion aide (MA) on 05/03/19 Resident #3's MAR when he lin injection. rer refused his Levemir			

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 24 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		F	,
		FCL001107	B. WING	<del></del>	1	3/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHER FAMILY CARE			DLY ROAD ON, NC 27216	<b>S</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 342}	had doses remaining since 02/25/19.  If he had documente administered what he Based on observation reviews, Levemir cou administered daily as #3's MAR's according dispensed from the plamount required for dunits.  b. Review of Residen 2019 Medication Adm revealed:  There was a comput FSBS twice daily sche 8:00pm.  Resident #3's FSBS daily from 02/01/19-0 Interview with Reside 10:30am revealed:  Staff had not taken had the The staff took his FShis FSBS "about two Review of Resident #05/03/19 at 9:00am rewere available.  Interview with the Adm (MA) on 05/03/19 at 13-He took Resident #3	Resident #3's Levemir pen when it had not been filled d on the MAR; he documented.  Ins, interviews, and record ld not have been documented on Resident g to the amount of Levemir harmacy compared to the laily administration of 35  It #3's February 2019-May hinistration Records (MARs)  er-generated entry to check eduled at 7:00am and  were documented twice 5/03/19.  Int #3 on 05/03/19 at his FSBS today, 05/03/19.  BS sometimes; staff took weeks ago."  3's glucometer supplies on evealed no FSBS test strips	{C 342}			
	Telephone interview v	vith the Pharmacist at the				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 25 of 33

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	A. BUILDING:			F	,	
		FCL001107	B. WING		1	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHER F	AMILY CARE	206 FRIEN BURLINGT	DLY ROAD ON, NC 27216	<b>3</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 342}	10:59am revealed: -A box of 50 glucome dispensed on 01/14/1 -There had been no or dispensed for Resider  A second interview with 05/03/19 at 1:00pm reduced.  He documented on Figure 1:00pm reduced his FSBSResident #3's FSBS resident #3's FSBS resident #3's FSBS resident #3's FSBS to pharmacy had dispended on the could not explain reviews, Resident #3's been checked daily at the could not explain reviews, Resident #3's MAR's according glucometer strips dispended to the amount to the amount of the could not explain reviews, Resident #3's MAR's according glucometer strips dispended to the amount of the amount of the amount of the could not explain the amount of the amount of the could not explain the amount of the amount	ter strips had been 9. other glucometer strips nt #3. ith the Administrator on evealed: Resident #3's MAR when he was checked twice daily. efused to check his FSBS. how he was able to check exice daily when the used 50 glucometer strips on tional strips had been  as, interviews, and record as FSBS could not have as documented on Resident go to the amount of bensed from the pharmacy unt required to check FSBS  at #3's physician order dated order for Ellipta, inhale Ellipta is a bronchodilator  a's February 2019 through a Administration Records er-generated entry for Ellipta as by mouth once daily for	{C 342}	DEFICIENC!)		
		tation Ellipta inhaler was am daily from 02/01/19				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 26 of 33

Division of Fleatin Service Regulation					1	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		FCL001107	B. WING		05/03/2019	
			1		1 00/00/2010	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MOHER F	AMILY CARE	206 FRIE	NDLY ROAD			
MOHER FAMILY CARE BURLINGT			TON, NC 27210	6		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(710)	
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI		
TAG	REGOLITOR OR E	is a second of the second of t	TAG	DEFICIENCY)	W/ (12	
			1.2.2.2.2			
{C 342}	Continued From page	e 26	{C 342}			
	through 05/03/19.					
	· ·					
	Observation of Reside	ent #3's medications on				
	hand on 05/03/19 at 9	9:00am revealed:				
	-There was an Ellipta	inhaler dispensed on				
	02/06/19.					
		ne Ellipta inhaler was 23				
	indicating the number	of remaining doses.				
	Interview with the Adr	ministrator/medication aide				
	(MA) on 05/03/19 at 9					
	. ,	s Ellipta inhaler every day.				
		out the Ellipta inhaler every				
	month.	but the Empta minater every				
		the label on the box was for				
	02/06/19.					
	-He could not explain	why there were 23				
	remaining doses on the	_				
	Interview with Reside	nt #3 on 05/03/19 at				
	10:30am revealed:					
	-He did not use his in	, ,				
		approximately two times per				
	week.	on he lest used his inhalan				
		en he last used his inhaler;				
	04/29/19).	nhaler this week, (week of				
	04/29/19).					
	Telephone interview v	vith a Pharmacist at the				
	facility pharmacy on 0					
	revealed:					
	-An Incruse Ellipta inh	naler was dispensed on				
	02/06/19 for Resident					
		naler was considered a bulk				
		d need to be reordered				
	monthly by the facility					
		sed his Ellipta daily as				
		ave ran out of medication in				
	early March 2019.					

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 27 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COMPLETED	
		FCL001107	B. WING		R <b>05/03/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MOHER F	MOHER FAMILY CARE  206 FRIE  BURLING			<b>3</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE	
{C 342}	05/03/19 at 1:00pm relate was the only MA medications.  He documented on FResident #3 used his He did not know why remaining since it had 02/06/19.  Based on observation Resident #3's Elliptal administered daily as #3's MAR's according inhaler dispensed from to the amount require medication daily.  2. Review of Resident 06/21/18 revealed dia dementia, type 2 diab accident old infarct, a essential hypertension abuse and vitamin D3 a. Review of subsequitof/21/18 revealed the checked daily, before Review of Resident #2019 Medication Admirevealed:  -There was a comput FSBS daily before bro-Resident #1's FSBS from 02/01/19-05/03/	ith the Administrator/MA on evealed: who administered  Resident #3's MAR when inhaler. In the inhaler had doses of not been filled since  Ins, interviews, and reviews, inhaler could not have been documented on Resident of the amount of Ellipta of the amount of Ellipta of the amount of Ellipta of the administer this  It #1's current FL-2 dated agnoses included vascular betes, cerebrovascular history of seizures, n, hyperlipidemia, tobacco of deficiency.  In the physician's order date of the ere was an order for FSBS of the breakfast.  It's February 2019-May inistration Records (MARs)  It's February 2019-May inistration Records (MARs)	{C 342}			
	pm revealed: -Staff had not taken h	is FSBS today, 05/03/19.				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 28 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING		_		
		FCL001107	B. WING		R 05/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHER E	MOHER FAMILY CARE					
		BURLINGT	ON, NC 27216	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{C 342}	Continued From page	28	{C 342}			
, ,	-Staff took his FSBS	once every three months; chis FSBS "was sometime	,			
		1's glucometer supplies on evealed FSBS test strips				
	facility's contracted pl 11:50 am revealed: -A box of 50 glucome dispensed in June 20 -There had been no co					
	(MA) on 05/03/19 at 1 -He took Resident #1 Resident #1 never ref -He used Resident #1 morning, 05/03/19He could not remem ordered test strips for Resident #1 had test admitted to the facility how many test strips -He never shared test -He thought had "just pharmacy whenever I he did not know test s counter items and that dispense test strips w	Is FSBS every morning; fused a FSBS. I's last test strip that ber the last time he had Resident #1 because strips with him when he was to but could not remember Resident #1 had. It strips between residents. picked up test strips" at the Resident #1 needed more; strips were not over the to the pharmacist could only with a prescription. Full to accurately document				
	Resident #1's FSBS of	ns, interviews, and reviews, could not have been umented on Resident #1's				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 29 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		R		
		FCL001107	B. WING		05/03/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHER FAMILY CARE			DLY ROAD ON, NC 27216	•		
	CLIMMADY CT		1		N agr	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
{C 342}	Continued From page	29	{C 342}			
	MAR's according to the strips dispensed from the amount required to the amount of the amount of Resident 2.5/2.5 mcg breathing. [(Stiolto Respiration used to compulmonary disease (Compulmonary	the pharmacy compared to to check FSBS daily.  It #1's physician's order led an order for Stiolto g inhale two puffs daily for espimat is a maintenance control chronic obstructive COPD)].  I's February 2019 through ealed: er-generated entry for le two puffs by mouth once 8:00 am. tation Stiolto Respimat ered at 8:00 am daily from				
	hand on 05/03/19 at 9 -There was a Stiolto R dispense date of 02/0 -The count indicator of that registered 60 puff -Sixty of 60 puffs were administered.  Telephone interview of facility's contracted pl 11:55 am revealed: -There was a Stiolto R on 02/06/19 for Resid -The inhaler containe prime the inhaler once puffs a day for thirty of -If Resident #1 had us	Respimat inhaler with a 16/19. On the inhaler had a gauge ifs available. The available to be with the Pharmacist at the narmacy on 05/03/19 at Respimat inhaler dispensed lent #1. If a cough medication to be and then administer two				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 30 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				R		
FCL001107		B. WING		05/03/2019		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MOHER E	AMILY CARE	206 FRIE	NDLY ROAD			
BURLING			TON, NC 27216		<u>,                                      </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{C 342}	Continued From page	e 30	{C 342}			
	ordered by the facility	t inhaler would need to be staff when it was empty.  nt #1 on 05/03/19 at 12:45				
	am revealed: -He had taken all his morning medication today, 05/03/19, and all his medication were pills; he did not use an inhalerHe could not remember when he last used an inhaler because "it had been so long ago"; he never refused to use his inhaler when he did have one.					
	Interview with the Administrator/medication aide (MA) on 05/03/19 at 2:00 pm revealed: -Resident #1 used his Stiolto Respimat inhaler every day; Resident #1 never refused to use his					
	inhalerHe always watched Resident #1 use the inhaler every morning, but he never checked the count indicator gauge for how much medication remained in the inhaler.					
	-He did not know the inhaler was full and that the counter still indicated there were sixty puffs availableHe could not remember the last time the inhaler had been dispensed; he thought the pharmacy automatically sent the inhalerHe was always careful to accurately document on the MAR"The MAR was correct."  Based on observations, interviews, and reviews, Resident #1's Stiolto Respimat inhaler could not have been administered daily as documented on Resident #1's MAR's according to the amount of Stiolto Respimat inhaler dispensed from the pharmacy compared to the amount required to					

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 31 of 33

PRINTED: 05/20/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		В	
		FCL001107	B. WING		R <b>05/03/2019</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOHER F.	AMILY CARE	206 FRIEND	DLY ROAD ON, NC 27216	•		
				PROVIDER'S PLAN OF CORRECTION	l ove	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	.ETE
{C 912}	Continued From page	: 31	{C 912}			
{C 912}	G.S. 131D-21(2) Decl	aration of Residents' Rights	{C 912}			
	Every resident shall h 2. To receive care an adequate, appropriate	ation of Resident's Rights ave the following rights: d services which are e, and in compliance with tate laws and rules and				
	reviews, the facility fa received care and ser appropriate, and in co federal and state laws	as evidenced by: as, interviews, and record filed to ensure residents vices which were adequate, ampliance with relevant and rules and regulations on administration and health				
	The findings are:					
	reviews, the facility fa sampled residents (Roresident who had a re and podiatrist as orde	esident #3) a diabetic ferral for an endocrinologist red by the primary care r to Tag C246 10A NCAC				
	reviews, the facility fa provider orders were sampled residents (# stick blood sugars (FS	ions, interviews, and record iled to assure primary care implemented for 2 of 3 I and #3) related to finger SBS). [Refer to Tag C249 b)(4) Health Care (Type B				
	3. Based on observat reviews, the facility fa	ions, interviews, and record iled to administer				

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 32 of 33

PRINTED: 05/20/2019 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
					R			
		FCL001107	B. WING		05/03/2019			
NAME OF PI	IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
MOHER FAMILY CARE  206 FRIENDLY ROAD  BURLINGTON, NC 27216								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	ETE		
{C 912}	Continued From page	÷ 32	{C 912}					
{C 912}	medications as ordereresidents (#1 and #3)	ed for 2 of 3 sampled related to physician's d Incruse Ellipta (#3) and Tag C330 10A NCAC	{C 912}					

Division of Health Service Regulation

STATE FORM 6899 D9V212 If continuation sheet 33 of 33