Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017026	A. BUILDING: _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & L FAMILY CARE	3023 CHANDLER MILL ROAD PELHAM, NC 27311

(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 May 11, 2021.	C 000	RECEIVED MAY 26 2021 ADULT CARE LICENSURE SECTION RALEIGH	
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 2 sampled residents (Resident #2) with orders for daily finger stick blood sugar (FSBS) checks. The findings are: Review of Resident #2's current FL-2 dated 02/24/21 revealed diagnoses included type 2 diabetes mellitus, hypertension, and vitamin D deficiency. Review of Resident #2's physician's order dated 06/30/20 revealed there was an order for finger stick blood sugar (FSBS) checks daily. Review of Resident #2's physician's order dated 12/18/18 revealed an order allowing Resident #2 to self-administer her FSBS checks. Review of Resident #1's medication	C 249		

POC reviewed and accepted 06/01/21. KG
Kathy Gray

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C 249	Continued From page 1 administration records (MAR) for March 2021, April 2021, and May 2021 revealed: -There was no entry to check Resident #2's FSBS daily. -There was no documentation Resident #2's FSBS was checked. Interview with Resident #2 on 05/11/21 at 11:56am revealed: -She checked her FSBS and documented it in a notebook she kept in her room. -Her primary care provider (PCP) told her she only needed to check her FSBS if she was feeling bad. -Sometimes she checked her FSBS when she was not feeling bad, "just to keep a check on it." Second interview with Resident #2 on 05/11/21 at 3:41pm revealed: -She had never shown the PCP her the notebook where she documented her FSBS, but she always told her the ranges and the PCP told her she was doing good. -The PCP always checked her FSBS in her office and the FSBS results were always "good" per the PCP. -The PCP told her about a year ago that she only needed to check her FSBS when she was not feeling well. -She did not know she was supposed to check her FSBS daily. Review of Resident #2's FSBS notebook on 05/11/21 revealed: -There was documentation Resident #2 checked her FSBS 17 times between 03/01/21-03/31/21; the readings ranged from 91-106. -There was documentation Resident #2 checked her FSBS 13 times between 04/01/21-04/30/21; the readings ranged from 89-105.	C 249		

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C 249	Continued From page 2 -There was documentation Resident #2 checked her FSBS 4 times between 05/01/21-05/11/21; the readings ranged from 84-109. -Resident #2's FSBS was documented as 84 on 05/11/21. Review of Resident #2's Licensed Health Professional Support (LHPS) assessment dated 03/31/21 revealed: -Resident #2's FSBS readings ranged between 92-103. -Resident #2 was a non-insulin-dependent diabetic and self-monitored her FSBS and recorded daily. Review of Resident #2's physician summary dated 02/09/21 revealed: -The visit was a virtual visit due to the COVID-19 pandemic. -The visit was a six-month follow-up. -Resident #2's last AIC was 6.2 (there was no date of the test). -Resident #2 reported her FSBS today, 02/09/21, was 100. -Current medications listed included blood glucose test strips once a day and lancets once a day. Observation of Resident #2's lancets revealed a box of 50 lancets that were dispensed on 04/26/21 were available. Interview with the Administrator on 05/11/21 at 1:45pm revealed: -Resident #2 had an order to self-administer her own FSBS checks. -She did not know how often Resident #2 checked her FSBS. -She did not monitor Resident #2 to make sure she checked her FSBS as ordered.	C 249		

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C 249	Continued From page 3 -She did not know Resident #2 had an order for daily FSBS and was not doing the FSBS checks daily. Telephone interview with the LHPS nurse on 05/11/21 at 2:05pm revealed: -Resident #2 did her own FSBS. -Resident #2 kept a book with her FSBS readings documented. -She had documented Resident #2 was supposed to do daily FSBS, but she knew Resident #2 did not do daily FSBS. -She did not know if the order had changed for Resident #2's FSBS. Interview with the Supervisor-in-Charge (SIC) on 05/11/21 at 4:00pm revealed: -Resident #2 checked her own FSBS. -He did not know how often Resident #2 checked her FSBS. -Resident #2 kept her own journal with the FSBS readings. -He did not know Resident #2 had an order for daily FSBS. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/11/21 at 3:13pm revealed: -They received an order for lancets to be used with a glucometer (a machine used to check FSBS) for Resident #2 on 06/30/20; the prescription was good for one year. -A box of 50 lancets was dispensed to Resident #2 on 04/26/21. Attempted interview with Resident #2's PCP on 05/11/21 at 3:14pm was unsuccessful.	C 249	Order for daily self blood glucose checks was shown to Resident # 2. Resident # 2 will check blood sugar daily and record on her log. She will show the log to the Administrator, [redacted], SIC, [redacted], to ensure compliance. Administrator or SIC will validate readings from her device to the log once a week for the first two weeks and then monthly thereafter. Readings will be recorded on the MAR once validation occurs. [redacted] RN will audit charts for new orders and make sure the MAR correlates with the orders on a monthly basis.	5/17/2021

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C 335	Continued From page 4	C 335		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by:	C 335		

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C 335	Continued From page 5 Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination for 4 of 4 residents (#1, #2, #3, and #4). The findings are: Observation of the dining room table on 05/11/21 at 8:34am revealed: -There were four clear plastic medication cups with multiple oral medications placed at four different place settings at the dining room table. -There was one cup that contained ten medications, four of the medications were white tablets, three were yellow tablets, one was an orange tablet, one was a blue and white capsule and one was a clear gel capsule. -There was one cup that contained eight medications, three were white tablets, one was a yellow tablet, one was a pink tablet, one was a green tablet, one was a clear capsule with a tan substance inside and there was a red gel capsule. -There was one cup that contained 2 pink tablets, and one large and one small clear gel capsule. -There was one cup that contained one small white tablet. -The cups were not labeled with the names of the residents to which the medications were to be administered. -The cups were not labeled with the medication contained in each cup. -The medication cups were not covered or sealed and therefore the medications inside the cups were not protected from contamination. -There were no residents at the dining room	C 335		

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C 335	Continued From page 6 table. -There was no staff present in the dining room. Observation of the sitting room adjacent to the dining room on 05/11/21 at 8:34am revealed two residents watching the television. Observation of the kitchen on 05/11/21 at 8:34am revealed the Administrator and a staff person were preparing the breakfast meal. Interview with the Administrator on 05/11/21 at 8:38am revealed: -She put each of the resident's medications in a clear cup and placed the cup at the resident's place setting at breakfast. -The residents always sat in the same seat at every meal. -She was taught to do each resident's medication one at a time and watch the resident take the medication. -She did not know why she put the medication in the cups, it was just easier. -She did not watch the residents take the medication, but she knew they always took it because they brought her the empty medication cup. -She did not label the cups because she knew where the residents sat at the table. -She did not know any medication that was pre-poured had to be labeled with the resident's name, medications, and covered to prevent the medication from being spilled or contaminated. Interview with three residents on 05/11/21 between 11:56am-12:14pm revealed: -Medications were always in clear medication cups at their place setting when they went to meals. -No one watched them take the medication; they	C 335		

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C 335	Continued From page 7 just took the medication in the cup and took the empty cup to the kitchen after they had finished their meal. Interview with the Supervisor-in-Charge (SIC) on 05/11/21 at 5:31pm revealed: -When he administered medication, he put the resident's medication in medication cups and placed them at the dining room table where the resident sat. -The residents all had a set place where they sat. -The residents usually went to the table within a few minutes of him placing the medication cups. -He knew he was not supposed to put the medication in cups on the dining room table, but he did it for convenience.	C 335	Administrator, [redacted], or SIC, [redacted], will call appropriate resident one at a time to the dining room table once their medication has been prepared and is ready for administration. In the event that the residents are all at the dining room table, the medication pass will be administered individually to the appropriate resident. The Administrator or SIC will observe each resident take all medications and will then document appropriately on the MAR. Medications will no longer be left unattended and all residents will be observed taking medications. [redacted], RN will conduct monthly audit to ensure compliance with above.	5/12/2021
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 1 of 1 sampled resident (Resident #1) with an order for a medication used to treat anxiety. The findings are:	C 367	Type text here	

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C 367	Continued From page 8 Review of Resident #1's current FL-2 dated 01/21/21 revealed: -Diagnoses included unspecified hypertension, chronic constipation gastroesophageal reflux disease, and glaucoma -There was a medication order for Clonazepam (used to treat anxiety) 0.5mg one tablet twice daily. Review of Resident #1's March 2021 medication administration record (MAR) revealed: -There was an entry for Clonazepam 0.5mg one tablet twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Clonazepam 0.5mg one tablet twice daily was administered 03/01/21-03/31/21 at 8:00am and 8:00pm. Review of Resident #1's April 2021 MAR revealed: -There was an entry for Clonazepam 0.5mg one tablet twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Clonazepam 0.5mg one tablet twice daily was administered 04/01/21-04/30/21 at 8:00am and 8:00pm. Review of Resident #1's May 2021 MAR revealed: -There was an entry for Clonazepam 0.5mg one tablet twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Clonazepam 0.5mg one tablet twice daily was administered 05/01/21-05/10/21 at 8:00am and 8:00pm. Review of Resident #1's control substance count sheets (CSCS) revealed: -There was a CSCS log dispensed with Resident	C 367	Type text here	

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C 367	Continued From page 9 #1's Clonazepam on 01/28/21 for 60-tablets. -The CSCS log documentation began with the date of 02/10 and ended with the date of 03/09. -There was documentation in the dose column of 0.5mg and was signed by the medication aide (MA), -There was no beginning or end balance documented. -There was a CSCS log dispensed with Resident #1's Clonazepam on 02/25/21 for 60-tablets. -The CSCS log documentation began with the date of 03/10 and ended with the date of 04/09. -There was documentation in the dose column of 0.5mg and was signed by the medication aide (MA), -There was no beginning or end balance documented. -There was a CSCS log dispensed with Resident #1's Clonazepam on 03/23/21 for 60-tablets. -The CSCS log documentation began with the date of 04/10 and ended with the date of 05/09. -There was documentation in the dose column of 0.5mg and was signed by the medication aide (MA), -There was no beginning or end balance documented. -There was no documentation on a CSCS log for 05/10/21 and 05/11/21. Observation of Resident #1's medication on hand of 05/11/21 at 11:22am revealed: -There was a punch card labeled for Clonazepam 0.5mg with a quantity of 31 tablets. -Each bubble was labeled with the date and time; the bubble for 05/10/21 and 05/11/21 at 8:00am had been dispensed. -There was a second punch card labeled for Clonazepam 0.5mg with a quantity of 31 tablets. -Each bubble was labeled with the date and time; the bubble for 05/10/21 at 8:00pm had been	C 367		

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C 367	Continued From page 10 dispensed. Telephone interview with the facility's registered nurse (RN) consultant on 05/11/21 at 2:05pm revealed: -She completed the facility's drug review quarterly. -Resident #1 was the only resident who was administered a controlled medication. -She usually looked at the CSCS when she completed her drug review. -The last drug review was completed virtually, and she did not recall reviewing a CSCS for Resident #1. -The Supervisor-in-Charge (SIC) should document the remaining balance when completing the CSCS. -It was an oversight on her part. Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/11/21 at 2:32pm revealed: -The facility was on cycle refills for Resident #1's medication, including Clonazepam. -The pharmacy included the CSCS with each dispensing. -The MAs should document the balance of Clonazepam after each administration to track the current balance of the medication. Interview with the Administrator on 05/11/21 at 1:10pm revealed: -She administered Resident #1's Clonazepam on 05/10/21 and 05/11/21. -She did not document on Resident #1's CSCS. -She only documented on Resident #1's MAR. -She was not used to signing the CSCS because the MA usually did it. Interview with the SIC on 05/11/21 at 4:00pm	C 367		

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C 367	Continued From page 11 revealed: -He administered Resident #1's Clonazepam. -He dated, wrote the dosage and signed the CSCS, each time the medication was administered. -He was documenting the balance of Clonazepam on hand, but he had stopped doing it. -He did not know how important it was to document the amount of Clonazepam on hand.	C 367	SIC, [redacted] and Administrator [redacted] were re-educated by [redacted] RN on appropriate administration and documentation of controlled substance/log. Education and observation of correct documentation on controlled substance log and balance forward and count verification occurred. Control Substance log will be filled out appropriately with the balance and count verification starting immediately. [redacted], RN will audit the control substance log on a bi-weekly basis to ensure compliance for the first month then quarterly thereafter. Re-education of staff to occur when deficiency is found. Control substance will continue to be locked in secure area.	5/12/2021
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		

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C 612	Continued From page 12 This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the Department of Health and Human Services (NC DHHS) were implemented when caring for 4 residents during the global Coronavirus (COVID-19) pandemic as related to staff and family members wearing a mask and the screening of staff, family members and visitors. The findings are: Review of the Center for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus in a long-term care (LTC) facility dated 04/27/21 revealed: -Staff should be screened for fever and signs and symptoms of illness before they began work. -Staff should wear a facemask at all times while they are in the facility. -Appropriate PPE should be used by personnel when in contact with the resident. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities 03/31/21 revealed: -LTC facilities must screen every individual each and every time they are wishing to enter the facility. -Ensure the facility policies comply with the latest guidance and educate staff about any policy changes. -Educate and monitor staff on the appropriate and consistent use of PPE in line with the guidance regarding coronavirus. -Facility should screen healthcare providers at the beginning of their shift for fever or respiratory	C 612	All staff will be screened for S/S of illness prior to beginning work. If an employee feels ill, they are to stay home and notify the facility. All staff not living at the facility will wear a facemask at all times while they are in the facility. Appropriate PPE will be utilized by staff when in contact with any resident. All visitors will be screened prior to entry into the facility for COVID 19 using the COVID screening tool developed by [redacted], RN per CDC recommendations. Administrator or SIC will screen employees and residents daily, logging their temperatures in the journal/binder kept at side entry door along with extra face coverings and sanitizer. SIC created COVID - 19 policy which will be onsite in the designated policy binder. He will update policy as needed following CDC guidelines. [redacted], RN will audit the screening log monthly then quarterly to ensure compliance.	5/17/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017026	A. BUILDING: _____ B. WING _____	05/11/2021

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C 612	Continued From page 13 symptoms. Review of the facility's policies revealed there was no written Infection Control Policy available at the time of the survey. 1. Observation upon entrance to the facility on 05/11/21 at 8:00am revealed: -The Administrator was not wearing a mask. -A staff person entered the facility and was not wearing a mask. Interview with three residents on 05/11/21 between 12:10pm-12:37pm revealed: -No one at the facility wore a mask. -Some staff wore masks before they had all received their vaccination. Second interview with the Administrator on 05/11/21 at 1:22pm revealed staff wore a mask prior to getting the vaccine. Interview with the SIC on 05/11/21 at 5:31pm revealed: -He wore his mask and washed his hands upon entering the facility. -He wore his mask until a couple of months ago after everyone was "fully" vaccinated. -He did not know staff and visitors should still wear a mask and that everyone should be screened. Refer to the interview with the Administrator on 05/11/21 at 8:10am. Refer to the second interview with the Administrator on 05/11/21 at 1:22pm. Refer to the interview with the SIC on 05/11/21 at 5:31pm.	C 612		

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C 612	Continued From page 14 2. Observation upon entrance to the facility on 05/11/21 at 8:00am revealed: -The Administrator met the surveyor at the entrance and was guided to the living room area. -The Administrator did not offer or request to check the surveyor's temperature or ask any screening questions upon entry. -There was no screening log at the entrance. Interview with three residents on 05/11/21 between 12:10pm-12:37pm revealed: -No one asked screening questions about symptoms of COVID-19. -No one had taken their temperature. Interview with the Administrator on 05/11/21 at 1:22pm revealed: -She had not checked the resident's temperatures during the pandemic. -Someone had sent a thermometer to the facility, but she had not had a reason to use it. -None of the residents had complained of not feeling well so there was no need to check their temperature. Observation of thermometers provided by the Administrator on 05/11/21 at 1:24pm revealed: -A box contained an infrared thermometer that had not been opened and the contents were enclosed in plastic. -A second thermometer had been opened but the Administrator thought the battery was not working. Interview with the SIC on 05/11/21 at 5:31pm revealed: -He started screening residents when the facility received a thermometer. -They did not have a system in place, just if	C 612		

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C 612	Continued From page 15 someone did not feel well, they would take their temperature. -He did not know residents, staff and visitors should be screened. Refer to the interview with the Administrator on 05/11/21 at 8:10am. Refer to the second interview with the Administrator on 05/11/21 at 1:22pm. Refer to the interview with the SIC on 05/11/21 at 5:31pm. Interview with the Administrator on 05/11/21 at 8:10am revealed: -She lived at the facility. -She had not been allowing visitors into the facility. -Everyone at the facility had been vaccinated. -The only people who went into the facility were a named staff person, her family member who was the Supervisor-in Charge (SIC) and his friend, and another family member. Second interview with the Administrator on 05/11/21 at 1:22pm revealed: -She did not have a policy related to COVID-19. -The only thing the facility did different during the COVID-19 pandemic was to "stay in" and not allow visitors. -All of the residents, staff, and family members had received the first dose of the vaccine on 01/18/21 and the second dose on 02/05/21. -Staff wore a mask prior to getting the vaccine. -She had not received updates about the guidelines for facilities, the SIC received the emails from the "state." Interview with the SIC on 05/11/21 at 5:31pm	C 612		

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C 612	Continued From page 16 revealed: -If he had received any emails with recommendations for the facility related to the COVID-19 pandemic, he had not seen the emails. -The facility did not allow visitors during the pandemic. -No one from the county health department had contacted him during the pandemic to provide guidance.	C 612		