STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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	C 000		
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 a resident referral was made and kept for 1 of 3 sampled residents (#2) related to a referral for an orthopedic consultation. The findings are: Review of Resident #2's current FL-2 dated 11/21/22 revealed diagnoses included schizophrenia, primary hypertension, intellectual development disability, and benign prostatic hyperplasia. Review of Resident #2's primary care provider's (PCP) after-visit summary revealed: -There was an order for Resident #2 to be seen at the orthopedic office. -A named orthopedic office and telephone number were listed with the instructions to call for an appointment. Telephone interview with a scheduling representative at the orthopedic office on 05/09/23 at 3:15pm revealed: -A referral was sent in on 03/14/23 for Resident #2. -The orthopedic office staff tried to call the	C 246		

Reviewed and acknowledged 06/15/23.
kg

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C 246	Continued From page 1 telephone number they were provided for Resident #2 and there was no answer. -The orthopedic office staff sent a letter to the address they were provided. -The telephone number and address were not for the current facility. Interview with Resident #2 on 05/09/23 at 5:14pm revealed: -He had not been to see an orthopedist. -His back hurt, "straight up the spine and up both sides." Telephone interview with Resident #2's PCP on 05/09/23 at 2:27pm revealed: -Resident #2 had spine problems and complained of back pain. -Resident #2 had an x-ray on 03/13/23 that revealed the resident had a lot of spinal issues, including narrowing of the lumbar spine and spinal arthritis. -Resident #2 needed to see an orthopedist. -She expected the order to have been followed through. Interview with the Administrator on 05/09/23 at 4:09pm revealed: -He was waiting for the orthopedic' s office to call him about an appointment for Resident #2's. -He did not know he was supposed to call to make an appointment for Resident #2.	C 246	The appointment has been set up for Wednesday 5.24.2023, with Reidsville Orthorpedic. The resident was seen on 5.24.2023. Administrator and MA staff will review all correspondence from PCPs to ensure orders and follow up appointments will be adhered to. Administrator and staff will have correspondence weekly, in regards to all orders.	5.11.2023 5.11.2023
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered	C 270		

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C 270	Continued From page 2 therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was a matching therapeutic diet menu to use for guidance when preparing meals for a resident who had a physician-ordered cardiac diet. The findings are: Review of Resident #2's current FL-2 dated 11/21/22 revealed diagnoses included schizophrenia, primary hypertension, intellectual development disability, and benign prostatic hyperplasia. Review of Resident #2 ' s hospital discharge summary dated 12/22/22 revealed an order for a cardiac diet (heart healthy). Observation of the kitchen on 05/09/23 at 9:32am revealed: -There was a regular menu posted on the side of the refrigerator. -There was no cardiac diet or heart-healthy diet posted for guidance. Observation of the lunch meal service on 05/09/23 at 12:44pm revealed: -All of the residents were served the same meal. -The meal consisted of meatballs, creamed potatoes, cabbage, and a slice of white bread. Interview with Resident #2 on 05/09/23 at 5:14pm revealed:	C 270	Updated menus featuring heart healthy diets have been put in place. All residents has been given updated dietary guidelines from their PCP Resident's PCP has concluded based on his current levels that a "regular diet will suffice.	5.12.2023 5.12.2023 5.11.2023

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C 270	Continued From page 3 -He was not on a special diet. -He ate whatever the cook fixed to eat. Interview with a medication aide (MA) on 05/09/23 at 1:42pm revealed: -All of the residents received the same meal unless she knew a resident did not like something she was serving. -None of the residents had a special diet. Telephone interview with Resident #2's PCP on 05/09/23 at 2:27pm revealed: -She did not know a heart healthy diet had been ordered when the resident was discharged from the hospital. -She expected the diet order to be followed. Interview with the Administrator on 05/09/23 at 1:57pm revealed: -He thought Resident #2 was on a regular diet. -He did not know Resident #2 ' s discharge papers had the diet listed as a cardiac diet (heart healthy). -He thought he had a heart-healthy diet menu and would locate the menu for guidance.	C 270		
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.	C 330		

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C 330	Continued From page 4 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1, #2) related to medication orders for a blood pressure medication, two medications used to control/lower blood sugar levels, and an eye drop (#1); an allergy nasal spray, and medication used to prevent constipation (#2). The findings are: 1. Review of Resident #1's current FL2 dated 08/19/22 revealed diagnoses included diabetes mellitus, hypertension, kidney disease, left leg amputee, glaucoma, and schizophrenia. a. Review of Resident #1's current FL2 dated 08/19/22 revealed there was an order for Lisinopril (used to treat high blood pressure) 10mg daily. Review of Resident #1's Medication Administration Record (MAR) for March 2023 revealed: -There was an entry for Lisinopril 10mg, hold if systolic blood pressure (SBP) is less than 100 with a scheduled administration time of 7:00am. -There was documentation Resident #1's Lisinopril 10mg was administered from 03/01/23-03/24/23 and 03/28/23-03/31/23. -There were no exceptions documented for 03/25/23-03/27/23. -There was no entry for a SBP and there was no documentation Resident #1's SBP had been taken before administering the Lisinopril.	C 330	Administrator will audit MARs weekly for one month. After one month Administrator will monitor biweekly. On the second month monitoring will be done monthly. In addition to the monitoring Administrator will train staff to monitor on weekly basis. Resident's bp is monitored and recorded daily, if SBP is less than 100 Lisinopril is held. All staff has been given this guidance and will be monitored by the Administrator.	6.13.2023 5.9.2023 5.9.2023

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C 330	Continued From page 5 Review of Resident #1's MAR for April 2023 revealed: -There was an entry for Lisinopril 10mg, hold if systolic blood pressure (SBP) is less than 100 with a scheduled administration time of 7:00am. -There was documentation Resident #1's Lisinopril 10mg was administered from 04/01/23-04/30/23. -There was no entry for a SBP and there was no documentation Resident #1's SBP had been taken before administering the Lisinopril. Review of Resident #1's MAR for May 2023 from 05/01/23-05/09/23 revealed: -There was an entry for Lisinopril 10mg, hold if systolic blood pressure (SBP) is less than 100 with a scheduled administration time of 7:00am. -There was documentation Resident #1's Lisinopril 10mg was administered from 05/01/23-05/09/23 -There was no entry for a SBP and there was no documentation Resident #1's SBP had been taken before administering the Lisinopril. Observation of Resident #1's medication on hand on 05/09/23 at 10:14am revealed: -There was a multi-dose punch card dispensed on 04/24/23. -Each bubble pack contained multiple tablets/capsules. -One of the medications was listed as Lisinopril 10mg, hold if SBP is less than 100. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/09/23 at 2:07pm revealed: -Resident #1's current order for Lisinopril was dated 04/17/23 with the directions to administer Lisinopril 10mg daily and to hold if the SBP was less than 100.	C 330		

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-The order for Resident #1's Lisinopril prior to 04/17/23 was dated 04/14/22 with the directions to administer Lisinopril 10mg daily and to hold if the SBP was less than 100.
-Lisinopril was packaged with other medications in a multi-dose package.
-Lisinopril was listed on the medication package with the order, Lisinopril 10mg, hold if SBP was less than 100.
-Resident #1's SBP should be checked prior to administering the Lisinopril 10mg.
-If Resident #1's SBP was not checked, and it was already running low, and the Lisinopril was administered, the resident could experience dizziness and be at risk for a fall.

Interview with a medication aide (MA) on 05/09/23 at 3:30pm revealed:
-She did not check Resident #1's SBP daily.
-She had not noticed that the directions included checking Resident #1's SBP and to hold if the SBP was less than 100.
-If she had seen those directions, she would have checked Resident #1's SBP before administering the medication.

Interview with another MA on 05/09/23 at 3:58pm revealed:
-He did not check Resident #1's SBP.
-He had not seen Resident #1's order to check the SBP before administering the Lisinopril.

Telephone interview with Resident #1's primary care provider (PCP) on 05/09/23 at 2:27pm revealed:
-Resident #1 had a few low SBP readings, and she wanted to make sure if his SBP was running low, that he did not receive a medication that would lower his SBP further.
-A low SBP could lead to hypotension which could

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cause dizziness, falls, and even death.
-Resident #1 had complained of chest pain to her before and a low blood pressure could have contributed to that complaint.
-She expected Resident #1's SBP to be checked before administering Lisinopril.

Interview with Resident #1 on 05/09/23 at 5:18pm revealed:
-The staff did not check his blood pressure.
-He felt "dizzy-headed" all the time.
-A staff member told him one of his medications made him feel that way, but he did not recall who the staff member was.

Review of Resident #1's PCP care notes revealed:
-On 02/08/23, Resident #1's SBP was documented as 103.
-On 03/08/23, Resident #1's SBP was documented as 112.
- On 04/13/23, Resident #1's SBP was documented as 121.

Interview with the Administrator on 05/09/23 at 4:09pm revealed:
-He administered Resident #1's medication when he worked.
-He might have seen the order to check Resident #1's SBP, but he had not "processed it" until now when he was asked about it.
-He audited his MARs in March 2023 but missed seeing the parameter directions and noting Resident #1's SBP was not being checked.
-He expected all staff, including himself, to read the medication order and administer the medication as ordered.

Observation of Resident #1's SBP checked by the MA on 05/09/23 at 6:07pm revealed a reading of

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C 330	Continued From page 8 120. b. Review of Resident #1's current FL2 dated 08/19/22 revealed there was an order for Levemir (used to treat high blood sugar) 100 units, inject 32 units; there was no other information with the order. Review of Resident #1's Medication Administration Record (MAR) for March 2023 revealed: -There was an entry for Levemir 100 units/ML, inject 33 units at the hour of sleep, hold if the resident did not eat, with a scheduled administration time of 7:00pm. -There was a letter H documented for 03/01/23, 03/07/23, 03/08/23, 03/15/23, 03/21/23-03/22/23, 03/28/23-03/29/23 and the exceptions for these dates on the back of the MAR was held, Resident #1 did not eat. -There was no documentation Levemir was administered 03/24-23-03/26/23 and no exceptions were documented on the back of the MAR. Review of Resident #1's blood glucose/sugar readings form for March 2023 revealed: -There were 8 columns; labeled for the date, times of 7:00am, 12:00pm, and 6:00pm, and finger stick blood sugar (FSBS) results for each time, and the last column was labeled for Levemir units and site. -On 03/02/23 at 6:00pm the FSBS was documented as 192 and there was no documentation of Levemir being administered. -On 03/03/23 at 7:00am, Resident #1's FSBS was documented as 221 and at 12:00pm the FSBS was documented as 240; there was documentation Resident #1 was administered another insulin that was used when the resident's	C 330		

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FSBS was over 200 (no time was documented).
-On 03/24/23 at 6:00pm, Resident #1's FSBS was documented as 170 and there was no documentation of Levemir being administered.
-On 03/25/23 at 7:00am, the FSBS was documented as 220, and Resident #1 was administered another insulin that was used when the resident's FSBS was over 200.

Review of Resident #1's MAR for April 2023 revealed:
-There was an entry for Levemir 100 units/ML, inject 33 units at the hour of sleep, hold if the resident did not eat, with a scheduled administration time of 7:00pm.
-There was a letter H documented for 04/04/23-04/05/23, 04/12/23, and 04/19/23, and the exceptions for these dates on the back of the MAR was held, Resident #1 did not eat.
-There was no documentation Levemir was administered 04/17/23 and no exceptions were documented on the back of the MAR.

Review of Resident #1's blood glucose/sugar readings form for April 2023 revealed:
-There were 7 columns; labeled for date, times of 7:00am, 12:00pm, and 6:00pm, and FSBS results for each time, the column previously labeled on the March 2023 documentation for Levemir units and site was not listed.
-There were 3 dates with documentation that 33 units of Levemir were administered.

Review of Resident #1's MAR for May 2023 from 05/01/23-05/09/23 revealed:
-There was an entry for Levemir 100 units/ML, inject 33 units at the hour of sleep, hold if the resident did not eat, with a scheduled administration time of 7:00pm.
-There was documentation Resident #1's Levemir

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C 330	Continued From page 10	C 330		

was administered on 05/01/23-05/02/23.
-On 05/03/23 the letter H was documented; the reason for the exception was not documented.
-There was no documentation Levemir was administered 05/04/23-05/08/23 and no exceptions were documented on the back of the MAR. .

Review of Resident #1's blood glucose/sugar readings form for May 2023 from 05/01/23-05/09/23 revealed:
-There were 8 columns; labeled for the date, times of 7:00am, 12:00pm, and 6:00pm, and FSBS results for each time, and the last column was labeled for Levemir units and site.
-Three dates had 33 units of Levemir documented as administered.
-There were 5 dates without any documentation.

Observation of Resident #1's medication on hand on 05/09/23 at 10:14am revealed:
-There was a bottle of Levemir insulin dispensed on 02/21/23.
-The vial contained ¼ bottle of Levemir.

Interview with Resident #1 on 05/09/23 at 5:18pm revealed:
-The staff checked his FSBS three times every day.
-He only received insulin if his FSBS was over 200.
-He did not know what insulin he received.
-Some days he did not need insulin.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/09/23 at 2:07pm revealed:
-Resident #1's current order for Levemir was to inject 33 units at bedtime and hold if the resident did not eat; the order was written on 12/28/22.

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C 330	Continued From page 11 -One vial of Levemir was dispensed on 12/28/22 and 02/21/23. -Levemir was not on a scheduled cycle fill to be dispensed and would have to be requested for a refill. -Levemir was a long-acting insulin. -If Levemir was not administered as ordered, and the resident's FSBS was high, the resident's FSBS could go even higher. -High FSBS can cause problems with eyes, kidneys, and other organs, and the resident was at risk of going into keto acidosis if the FSBS went high enough, over 500. -Resident #1's Levemir should be administered as ordered to prevent his FSBS from elevating. Interview with a medication aide (MA) on 05/09/23 at 3:30pm revealed: -She checked Resident #1's FSBS before meals. -Levemir was scheduled to be administered at 7:00pm but was held if the resident did not eat or did not eat much. -She documented on the MAR when she held the Levemir by putting the letter H where initials were documented; H meant held. -She would administer Resident #1's Levemir if he ate starchy food such as potatoes or rice, but if he only ate a little something off his plate that was not starchy, she did not administer the Levemir. Interview with another MA on 05/09/23 at 3:58pm revealed: -He checked Resident #1's FSBS before meals. -He did not administer Resident #1's Levemir if his FSBS was less than 200. -If he gave Levemir when Resident #1's FSBS was 150-160, the resident's FSBS would be "really low" the next day. -If he administered Levemir it would be	C 330		

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C 330	Continued From page 12 documented and if he did not administer Levemir he did not document anything. Telephone interview with Resident #1's primary care provider (PCP) on 05/09/23 at 2:27pm revealed: -Resident #1 had an order to administer 33 units of Levemir nightly. -She had the parameter for holding if the resident did not eat because if he did not eat anything and his FSBS was low, "below 80" the Levemir could cause the FSBS to drop too low. -She only meant for the Levemir to be held if the resident did not eat anything, -If the resident ate anything and his FSBS was above 80, she wanted Levemir to be administered. -If Resident #1's Levemir was not administered his FSBS could go too high, and he could become hyperglycemic. -Resident #1 already lost one limb, and he would be at risk of losing another limb. -If Resident #1's FSBS was high it could cause damage to his eyes, kidneys, and heart. Interview with the Administrator on 05/09/23 at 4:09pm revealed: -He administered Resident #1's Levemir. -There had been a few times (he did not recall a specific date), Resident #1 did not eat, and he did not administer the Levemir. -He should have documented this on the MAR as an exception. Observation of Resident #1's FSBS checked by the MA on 05/09/23 at 6:13pm revealed a reading of 109. c. Review of Resident #1's current FL2 dated 08/19/22 revealed there was no order for Novolog	C 330	MA staff has been educated on proper documentation of FSBS and insulin injections. Administrator will monitor FSBS records biweekly to ensure that all MAs are properly documenting and administrating insulins. FSBS forms has been updated to include both injections Levemir and Novolg. In addition, staff will use MARs given by pharmacy to site administration as well.	5.10.2023 5.10.2023 5.10.2023

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C 330	Continued From page 13 (short acting insulin, used to treat high blood sugar). Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/09/23 at 2:07pm revealed: -Resident #1's current order for Novolog was to inject 2 units before meals if the resident's FSBS was greater than 200 and hold if the resident did not eat. -The order was written on 04/06/22; there were no other orders for Novolog. -One vial of Novolog was dispensed on 12/28/22 and 02/21/23. -Novolog was not on a schedule to be cycle filled and would have to be requested for refill. -Novolog was a fast-acting insulin. -If the Novolog was not administered as ordered, and the resident's FSBS was high, the resident would not feel well. -Resident #1's Novolog should be administered as ordered to lower the resident's FSBS. Review of Resident #1's Medication Administration Record (MAR) for March 2023 revealed: -There was an entry for Novolog 100u/ml, inject 2 units three times a day if the FSBS was greater than 200 and the resident ate a meal; hold if the resident did not eat. -Novolog was documented as administered on 03/01/23 at 8:00am and 12:00pm, 03/08/23 at 5:00pm, 03/28/23 at 5:00pm, and 03/29/23 at 12:00pm. Review of Resident #1's blood glucose/sugar readings form for March 2023 revealed: -There were 8 columns; labeled for the date, times of 7:00am, 12:00pm, and 6:00pm, and FSBS results for each time, and the last column	C 330		

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was labeled for Levemir units and site.
-Resident #1's FSBS was documented as greater than 200 on 18 occasions.
-Under the column for Levemir there was documentation 2 units of Novolog was administered on 11 occasions.
-There was no documentation Novolog was administered on 7 of the 18 occasions Resident #1's FSBS was documented as greater than 200, but 5 of the 18 occasions Resident #1's FSBS was documented as greater than 200, Novolog was documented as administered on the MAR, which leaves no documentation for 2 occasions the resident's FSBS was greater than 200.

Review of Resident #1's MAR for April 2023 revealed:
-There was an entry for Novolog 100u/ml, inject 2 units three times a day if the finger stick blood sugar (FSBS) was greater than 200 and the resident ate a meal; hold if the resident did not eat.
-Novolog was documented as administered on 04/04/23 for a FSBS of 244, 04/05/23 for a FSBS of 223, and 04/11/23 for a FSBS of 233.

Review of Resident #1's blood glucose/sugar readings form for April 2023 revealed:
-There were 8 columns; labeled for the date, times of 7:00am, 12:00pm, and 6:00pm, and FSBS results for each time, and the last column; there was no column for units.
-Resident #1's FSBS was documented as greater than 200 on 12 occasions.
-On the back of the form, Novolog was documented as administered on 04/01/23 at 12:00pm for a FSBS of 220 and on 04/02/23 at 12:00pm for a FSBS of 245.
-Novolog 2 units, were documented as administered on 2 of the 12 occasions Resident

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#1's FSBS was greater than 200.
-There was no other documentation Novolog was administered, but 3 of the 12 occasions Resident #1's FSBS was documented as greater than 200, Novolog was documented as administered on the MAR, which leaves no documentation for 7 occasions the resident's FSBS was greater than 200.

Review of Resident #1's MAR for May 2023 from 05/01/23-05/09/23 revealed:
-There was an entry for Novolog 100u/ml, inject 2 units three times a day if the finger stick blood sugar (FSBS) was greater than 200 and the resident ate a meal; hold if the resident did not eat.
-Novolog was not documented as administered.

Review of Resident #1's blood glucose/sugar readings form for May 2023 revealed:
-There were 8 columns; labeled for the date, times of 7:00am, 12:00pm, and 6:00pm, and FSBS results for each time, and the last column was labeled for Levemir units and site.
-Resident #1's FSBS was documented as greater than 200 on 4 occasions.
-There was no column for Novolog and no documentation Novolog was administered on 4 of the 4 occasions Resident #1's FSBS was documented as greater than 200.

Observation of Resident #1's medication on hand on 05/09/23 at 10:14am revealed:
-There was a bottle of Novolog insulin dispensed on 02/21/23.
-The vial contained less than ¼ bottle of Novolog.
-A vial of Novolog contains 500 doses based on 2 units daily.

Interview with a medication aide (MA) on

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C 330	Continued From page 16 05/09/23 at 3:30pm revealed: -She checked Resident #1's FSBS before meals. -If Resident #1's FSBS was over 200, she administered 2 units of Novolog and documented it as a PRN on the MAR. Interview with another MA on 05/09/23 at 3:58pm revealed: -He checked Resident #1's FSBS before meals. -He administered Resident #1's Novolog if his FSBS was higher than 250. -If he administered Novolog it would be documented and if he did not administer Novolog he did not document anything. -He did not recall the last time he administered Resident #1's Novolog, "but it would be documented." Telephone interview with Resident #1's primary care provider (PCP) on 05/09/23 at 2:27pm revealed: -Resident #1 had an order to administer 2 units of Novolog when the resident's FSBS was higher than 200, to get the FSBS down quickly. -"Just like the resident's Levemir, the insulin needed to be administered as ordered or the resident could have long-term effects of high FSBS. -Resident #1 already lost one limb, and he would be at risk of losing another limb. -If Resident #1's FSBS was high it could cause damage to his eyes, kidneys, and heart. Interview with the Administrator on 05/09/23 at 4:09pm revealed: -He administered Resident #1's Novolog when the resident's FSBS was greater than 200. -He had administered the Novolog, and it would be documented on the MAR.	C 330		

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Interview with Resident #1 on 05/09/23 at 5:18pm revealed:
-The staff checked his FSBS three times every day.
-He only received insulin if his FSBS was over 200.
-He did not know what insulin he received.
-Some days he did not need insulin.

Observation of Resident #1's FSBS checked by a MA on 05/09/23 at 6:13pm revealed a reading of 109.

d. Review of Resident #1's current FL2 dated 08/19/22 revealed there was an order for Latanoprost (used to treat glaucoma) 0.005%. (There were no directions).

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/09/23 at 2:07pm revealed:
-Resident #1's order for Latanoprost was received on 07/18/22 with the direction to place one drop in each eye at bedtime.
-Resident #1's Latanoprost was dispensed on 07/18/22 and 02/21/23 for a 25-day supply each dispensing.
-Latanoprost was used to lower eye pressure in people with glaucoma.
-If Resident #1's Latanoprost was not administered as ordered the resident's eye pressure could be elevated.
-Elevated eye pressure increased a resident's risk of vision problems including blurring, and trouble focusing; long term it could cause permanent eye damage.

Interview with Resident #1 on 05/09/23 at 5:18pm revealed:
-He could not see "too good" and thought he

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C 330	Continued From page 18 needed glasses. -He used to get eye drops every night, but he had not had eye drops in a while. -They "used to do it every day" but he did not know why they stopped. -He asked a MA once about the eye drops and the MA gave them to him. -He had not asked any other MAs about the eye drops. Review of Resident #1's Medication Administration Record (MAR) for March 2023 revealed: -There was an entry for Latanoprost, instill 1 drop in both eyes at bedtime. -There was documentation Resident #1's Latanoprost was administered from 03/01/23-03/12/23 and 03/14/23-03/23/23, and 03/27/23-03/30/23. -There was no documentation Latanoprost was administered on 03/13/23, 03/24/23-03/26/23, and 03/31/23. Review of Resident #1's MAR for April 2023 revealed: -There was an entry for Latanoprost, instill 1 drop in both eyes at bedtime. -There was documentation Resident #1's Latanoprost was administered from 04/01/23-04/30/23. Review of Resident #1's MAR for May 2023 from 05/01/23-05/09/23 revealed: -There was an entry for Latanoprost, instill 1 drop in both eyes at bedtime. -There was documentation Resident #1's Latanoprost was administered from 05/01/23-05/04/23 and 05/06/23-05/08/23. -There was no documentation Latanoprost was administered on 05/05/23.	C 330	Latanoprost administration education has been given to all staff. In addition staff will be monitored to ensure the medication is given and recorded properly. Administrator will audit MARs weekly for one month. After one month Administrator will monitor biweekly. On the second month monitoring will be done monthly. In addition to the monitoring Administrator will train staff to monitor on weekly basis.	5.10.2023 6.13.2023

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C 330	Continued From page 19 Observation of Resident #1's medication on hand on 05/09/23 at 10:14am revealed: -There was a bottle of Latanoprost eye drops provided by the medication aide (MA). -The bottle did not have a pharmacy label and the box was not available. -There was less than ¼ the medication remaining in the bottle. Interview with a MA on 05/09/23 at 3:30pm revealed: -She administered Resident #1's eye drops at bedtime, one drop in each eye. -She had not any problems with administering Resident #1's eye drops, "he lets me do it." -She did not know why there would be medication remaining if the bottle only lasted 25 days. -Refills on the Latanoprost had to be requested. Interview with another MA on 05/09/23 at 3:58pm revealed: -He administered Resident #1's eye drops every night. -He did not know why Resident #1's had not run out, but he did recall Resident #1 had an extra bottle of eye drops at one time, "it was a while back." Telephone interview with Resident #1's primary care provider (PCP) on 05/09/23 at 2:27pm revealed: -Resident #1 had glaucoma and if his Latanoprost was not administered as ordered, he could have intraocular pressure, which could worsen the glaucoma and cause blindness. Interview with the Administrator on 05/09/23 at 4:09pm revealed: -He administered Resident #1's Latanoprost at	C 330	Staff has been educated on obtaining additional medicines from the pharmacy. Administrator will screen all loose medications to ensure they are being used at the proper rate. In addition Administrator will train all med staff on properly observing rates at which loose medical supplies should be used.	5.10.2023 6.13.2023

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C 330	Continued From page 20 bedtime. -He thought Resident #1 had another bottle of Latanoprost that had been dispensed. 2. Review of Resident #2's current FL-2 dated 11/21/22 revealed diagnoses included schizophrenia, primary hypertension, intellectual development disability, and benign prostatic hyperplasia. a. Review of Resident #2's current FL2 dated 11/21/22 revealed there was an order for Miralax (used to treat constipation)17g daily. Interview with Resident #2 on 05/09/23 at 5:14pm revealed: -He had problems with constipation. -He needed to go right now but he could not. -His stool was "hard like cardboard." -His stomach was hurting, and his back was hurting too. -He did not know if he received medication for constipation, but he did get stuff to drink every morning like milk and juice. Review of Resident #2's Medication Administration Record (MAR) for March 2023 revealed: -There was an entry for Miralax mix 17g (one capful) in 8 ounces of juice or water daily. -There was no documentation Resident #2's Miralax was administered on 03/20/23-03/21/23 and 03/25/23-03/27/23, and no exceptions were documented. Review of Resident #1's MAR for April 2023 revealed: -There was an entry for Miralax mix 17g (one capful) in 8 ounces of juice or water daily. -There was documentation Resident #2's Miralax	C 330	Staff has been educated on administering Miralax as prescribed.	5.10.2023

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C 330	Continued From page 21 was administered from from 04/01/23-04/30/23. Review of Resident #1's MAR for May 2023 from 05/01/23-05/09/23 revealed: -There was an entry for Miralax mix 17g (one capful) in 8 ounces of juice or water daily. -There was no documentation Resident #2's Miralax was administered on 05/06/23-05/07/23, and no exceptions were documented. Observation of Resident #2's medication on hand on 05/09/23 at 11:19am revealed: -There was a bottle of Miralax dispensed on 12/22/23 for Resident #1. -There was approximately 1/4 of the medication remaining in the bottle. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/09/23 at 2:07pm revealed: -The only dispensing for Resident #2's Miralax was on 12/22/22 for a 30-day supply. -If Resident #2's Miralax was not administered as ordered the resident could have problems with constipation. Interview with a medication aide (MA) on 05/09/23 at 3:30pm revealed: -She administered Resident #2's Miralax and administered it on the mornings she worked. -He had not refused, but she may have to encourage him to drink it all. -Resident #2 had not complained of constipation that she was aware of. -She did not know why there would be medication remaining if the bottle only lasted 30 days. Interview with another MA on 05/09/23 at 3:58pm revealed: -He administered Resident #2's Miralax every day	C 330		

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he worked.
-He mixed a capful of Miralax with liquid and administered it to Resident #2.
-There had been a couple of times he had gotten busy and forgot to administer Resident #2's Miralax.
-If he did not administer the Miralax he would not have documented he administered it.

Telephone interview with Resident #1's primary care provider (PCP) on 05/09/23 at 2:27pm revealed:
-Miralax was used to prevent constipation.
-Resident #2 could have a constipation issue which could cause pain and discomfort.
-Residents could become so constipated that they could become septic.
-She expected Resident #2's Miralax to be administered as ordered.

Interview with the Administrator on 05/09/23 at 4:09pm revealed:
-Resident #2 had not complained of any constipation.
-Resident #2 sometimes took the Miralax and sometimes did not.
-If Resident #2 did not take his Miralax it would be documented on the MAR as a refusal.
-He did not know why Resident #2 still had Miralax available in a bottle dispensed on 12/22/22.

b. Review of Resident #2's current FL2 dated 11/21/22 revealed there was an order for Fluticasone (used to treat allergy symptoms) one spray each nostril daily.

Interview with Resident #2 on 05/09/23 at 5:14pm revealed:
-He had been "unusually sneezing", "I usually do

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C 330	Continued From page 23 not sneeze a lot." -He did not receive his Fluticasone every day, but on some days. Review of Resident #2's Medication Administration Record (MAR) for March 2023 revealed: -There was an entry for Fluticasone one spray in each nostril daily. --There was no documentation Resident #2's Miralax was administered on 03/20/23-03/21/23 or 03/25/23-03/27/23 and there were no exceptions documented. Review of Resident #1's MAR for April 2023 revealed: -There was an entry for Fluticasone one spray in each nostril daily. -There was documentation Resident #2's Fluticasone was administered from 04/01/23-04/30/23. Review of Resident #1's MAR for May 2023 from 05/01/23-05/09/23 revealed: --There was an entry for Fluticasone one spray in each nostril daily. -There was no documentation Resident #2's Fluticasone was administered on 05/06/23-05/07/23 and there were no exceptions documented. Observation of Resident #2's medication on hand on 05/09/23 at 11:19am revealed: -There was a bottle of Fluticasone dispensed on 12/22/23 for Resident #1. -There was ½ bottle of medication remaining. Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/09/23 at 2:07pm revealed:	C 330	Staff was educated on administering Fluticasone spray and proper documentation if there is a refusal.	5.10.2023

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C 330	Continued From page 24 -Resident #2's Fluticasone was dispensed on 12/22/22 and 01/23/23 for a 60-day supply. -If Resident #2's Fluticasone was not administered as ordered the resident could experience an increase in allergy symptoms. Interview with a medication aide (MA) on 05/09/23 at 3:30pm revealed: -She administered Resident #2's Fluticasone. -She would allow the resident to spray the medication into his nostrils. -She watched Resident #2 spray the medication and it appeared he was pushing the applicator all the way down and into both nostrils. -She did not know why there would be medication remaining if the bottle only lasted 60 days. Interview with another MA on 05/09/23 at 3:58pm revealed: -Resident #2's Fluticasone was an as needed (PRN) medication. -He administered Resident #2's Fluticasone when the resident needed it. -Resident #2 had not requested his Fluticasone. Telephone interview with Resident #1's primary care provider (PCP) on 05/09/23 at 2:27pm revealed: -Fluticasone was ordered for seasonal allergies, sneezing, and runny nose. -Resident #2 would not have relief from the symptoms associated with seasonal allergies if the medication was not administered as ordered. Interview with the Administrator on 05/09/23 at 4:09pm revealed: -He had administered Resident #2's Fluticasone. -He did not know why Resident #2 would still have Fluticasone available if the amount dispensed would not have been enough for the	C 330	MA staff was educated on checking and recording when medical supplies should expire. At or before expiration dates the staff will then contact the pharmacist to obtain additional supplies. The administrator will monitor weekly to ensure compliance. Administrator will monitor loose medical supplies for the rate of use. Administrator will continue to educate staff on how to properly gauge the amount of loose medicine used to ensure that new medicines are ordered in a timely manner.	5.10.2023 6.13.2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	05/09/2023

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C 330	Continued From page 25 time the medication was documented as administered. The facility failed to ensure medications were administered as order related to a resident who had an order for daily blood pressure checks and to hold the blood pressure medication if the systolic blood pressure was less than 100, causing risk for hypotension, a long-acting insulin to be administered every night unless the resident did not eat, and was unable to determine when the insulin was administered and when it was held, and a short-acting insulin that was not administered with a blood sugar greater than 200, placing the resident at risk with hyperglycemia, and eye drops were not administered as ordered to treat glaucoma, putting the resident at risk for elevated eye pressure which could cause difficulty with vision (#1). This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/09/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 23, 2023.	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;	C 342		

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 342	Continued From page 26 (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 completed for 3 of 3 sampled residents (#1, #2, #3). The findings are: 1. Review of Resident #1's current FL2 dated 08/19/22 revealed: -Diagnoses included diabetes mellitus, hypertension, kidney disease, left leg amputee, glaucoma, and schizophrenia. -There was an order for Aspirin (used to prevent blood clots) 81mg daily. -There was an order for Atorvastatin (used to treat high cholesterol) 80mg once daily at 6:00pm. Review of Resident #1's medication administration record (MAR) for May 2023 from 05/01/23-05/09/23 revealed:	C 342		

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C 342	Continued From page 27	C 342		

-There was an entry for Aspirin 81mg with a scheduled administration time of 7:00am.
-There was no documentation that Aspirin 81mg was administered on 05/07/23.
-There was an entry for Atorvastatin 80mg with a scheduled administration time of 6:00pm.
-There was no documentation Atorvastatin 80mgwas administered on 05/07/23.

Observation of Resident #1's medications on hand on 05/09/23 at 10:14am revealed Aspirin and Atorvastatin were available to be administered.

Interview with the Administrator on 05/09/23 at 4:09pm revealed he administered Resident #3's medications on 05/05/23-05/07/23.

Refer to the interview with the Administrator on 05/09/23 at 4:09pm.

2. Review of Resident #2's current FL-2 dated 11/21/22 revealed:
-Diagnoses included schizophrenia, hypertension, intellectual development disability, and benign prostatic hyperplasia.
-There was an order for Depakote (used to treat bipolar disorders) 500mg twice daily.
-There was an order for Famotidine (used to treat reflux disease) 20mg daily.
-There was an order for Levothyroxine (used to treat hypothyroidism) 25mcg daily.

Review of Resident #2's medication administration record (MAR) for May 2023 from 05/01/23-05/09/23 revealed:
-There was an entry for Depakote 500mg with a scheduled administration time of 800am and 8:00pm.
-There was no documentation that Depakote

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500mg was administered from 05/05/23 at 8:00pm-05/07/23.
-There was an entry for Famotidine 20mg with a scheduled administration time of 8:00am.
-There was no documentation that Famotidine 20mg was administered on 05/06/23-05/07/23.
-There was an entry for Levothyroxine 25mg with a scheduled administration time of 8:00am.
-There was no documentation that Levothyroxine 25mg was administered on 05/06/23-05/07/23.

Observation of Resident #2's medications on hand on 05/09/23 at 11:19am revealed Depakote, Famotidine, and Levothyroxine were available to be administered.

Interview with the Administrator on 05/09/23 at 4:09pm revealed he administered Resident #2's medications on 05/05/23-05/07/23.

Refer to the interview with the Administrator on 05/09/23 at 4:09pm.

3. Review of Resident #3's current FL-2 dated 11/21/22 revealed:
-Diagnoses included schizophrenia, primary hypertension, vitamin D deficiency, and a history of kidney failure.
-There was an order for Fluvoxamine Maleate (used to treat obsessive-compulsive disorder) 100mg take one tablet daily at bedtime.
-There was an order for Gemfibrozil (used to treat high cholesterol) 600mg take one tablet twice a day 30 minutes before morning and evening meals.
-There was an order for Vitamin D3 (supplement) 2000IU take one tablet daily.

Review of Resident #3's medication administration record (MAR) for May 2023 from

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C 342	Continued From page 29 05/01/23-05/09/23 revealed: -There was an entry for Fluvoxamine Maleate 100mg with a scheduled administration time of 7:00pm. -There was no documentation that Fluvoxamine Maleate 100mg was administered from 05/05/23-05/07/23. -There was an entry for Gemfibrozil 600mg with a scheduled administration time of 7:00am and 5:00pm. -There was no documentation that Gemfibrozil 600mg was administered from 05/05/23 at 5:00pm-05/07/23. -There was an entry for Vitamin D3 2000IU with a scheduled administration time of 8:00am. -There was no documentation that Vitamin D3 2000IU was administered from 05/06/23-05/07/23. Observation of Resident #3's medications on hand on 05/09/23 at 12:00pm revealed Fluvoxamine Maleate, Gemfibrozil, and Vitamin D3 were available to be administered. Interview with the Administrator on 05/09/23 at 4:09pm revealed he administered Resident #3's medications on 05/05/23-05/07/23. Refer to the interview with the Administrator on 05/09/23 at 4:09pm. _____ Interview with the Administrator on 05/09/23 at 4:09pm revealed: -He forgot to document the administration on the MAR. -He knew he was supposed to document on the MAR after every medication administration. -He just got in a hurry and forgot.	C 342	Administrator will review all Medical Administration Records daily. In addition all MA staff will review MARs to hold all accountable. Administrator will monitor Records weekly for one month. On the second month the monitoring will be biweekly. On the third month records will be once a month. Staff will be trained to monitor records on a weekly basis with the Administrator's supervision. Lonnie Graves, Administrator	5.9.2023 6.13.2023 5.24.2023