Recieved via email 10/18/23

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
			A. BUILDING:			R
		FCL001184	B. WING			K /31/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ELIA 1 FA	MILY CARE HOME		ENDLY ROAD			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
C 000	Initial Comments		C 000			
		nsure Section conducted an p survey on August 30, 2023				
C 202	10A NCAC 13G .07 Medical Examination	02(a) Tuberculosis Test and n	C 202			
	Medical Examination (a) Upon admission resident shall be tes in compliance with the by the Commission of specified in 10A NC, subsequent amender the rule are available the Department of H Tuberculosis Contro	02 Tuberculosis Test and n to a family care home each ted for tuberculosis disease he control measures adopted for Health Services as AC 41A .0205 including nents and editions. Copies of e at no charge by contacting lealth and Human Services, I Program, 1902 Mail Service rth Carolina 27699-1902.				
	facility failed to ensu	iews and interviews, the re 2 of 3 residents (#2 and uberculosis (TB) testing upon ance with the control				
	The findings are:					
	1.Review of Residen revealed:	t #2's FL-2 dated 08/09/23				
	coronary artery disea	hypertension, prediabetes, ase (CAD), left ventricular mentia, and cerebral				
	infarction.	was not documented.				
	Review of Resident #					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Recieved on 10/18/23

TITLE

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(X6) DATE

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6899 Type text here

P.D. 10/27/23

If continuation sheet 1 of 37

The Plan of Correction with addendum was reviewed and acknowledged on 10/27/23. Refer to addendums on pages 10, 11 and 37 of this STtement of Deficiencies.

STATEMENT	of Health Service Regi OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING.			R
		FCL001184	B. WING		08	/31/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
ELIA 1 FA	MILY CARE HOME		ENDLY ROAD GTON, NC 27217			8
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES 3Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
C 202	Continued From pag	e 1	C 202			
		ere was no admission date mented and no dated				
		#2's record on 08/30/23 to tuberculosis (TB) skin review.				
	11:04am revealed he	ent #2 on 08/31/23 at e did not recall a TB test n the past few weeks or since ne facility.				
	(CMA) at the facility's provider's (PCP) offic	with a certified medical aide s contracted primary care ce on 08/31/23 at 11:20am 2 had not been seen by the				
	08/30/23 at 9:01am r	edication Aide (MA) on evealed Resident #2 had facility about a week ago.				
	9:22am revealed: -When Resident #2 v told the resident alrea	ministrator on 08/31/23 at vas admitted he had been ady had a TB test done. the information provided by				
	when the resident wa -He was responsible were complete.	as admitted. for ensuring the TB test				
	revealed:	t #3's FL-2 dated 08/17/23				
	hypertension, demen reflux disease (GER					
	-The admission date	was not documented.				
	Review of Resident #	3's Resident Register on				

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If continuation sheet 2 of 37

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL001184	B. WING		R 08/31/2023
AME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE	•
		206 FRI	ENDLY ROAD		
ELIA1F/	AMILY CARE HOME	BURLIN	GTON, NC 2721	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE
C 202	Continued From pag	e 2	C 202		
		ere was no admission date mented and no dated			
		[£] 3's record on 08/30/23 o tuberculosis (TB) skin eview.			
		dministered about a week ire provider's (PCP) office. blood for the test.			
	(CMA) at the facility's provider's (PCP) offic revealed:	with a certified medical aide contracted primary care e on 08/31/23 at 11:20am od drawn for a TB Gold Plus			
	test on 08/18/23 but to contaminated and ha	he sample was			
	08/30/23 at 9:01am r	dication Aide (MA) on evealed Resident #3 had facility about a week ago.		.0	
	9:22am revealed: -When Resident #3 w told the resident alrea	ninistrator on 08/31/23 at vas admitted he had been ady had a TB test done . the information provided by		THE REP THAT BROT THE REMDENT INFO THE ADMINISTRATOR	North Roto At As MARE
	when the resident wa -He was responsible were complete.	s admitted. for ensuring the TB test		portones. THE TB	7255
C 212	10A NCAC 13G .070	3 (a) Resident Register	C 212	ADMINISIRATIOR WIL ENSURE THAT TB	~

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STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
					F	R
		FCL001184	B. WING		08/3	1/2023
IAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
elia 1 Fa	MILY CARE HOME		ENDLY ROAD GTON, NC 2721	7		
(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 APPROF DEFICIENCY)	DBE	(X5) COMPLETE DATE
C 212	Continued From page	e 3	C 212	PROTESS IS FULLY LON	nerens)
	10A NCAC 13G .070	3 Resident Register		PROTESS IS FULLY LON PRIOR TO ADMISSION TO THE LARE HOM	CN C	9/3/20
	(a) A family care hor	ne's administrator or		TO THE LARE HOM	E.	, ,
	supervisor-in-charge	and the resident or the				
	-	e person shall complete and gister within 72 hours of the				1
	resident's admission	to the home. The Resident				
		on the internet website, .state.nc.us/gcpage.htm, or				
	at no charge from the					
		Licensure Section, 2708				
		Raleigh, NC 27699-2708. a resident information form				
		ent Register as long as it				
	contains at least the s Resident Register.	same information as the			LDO	
	Resident Register.			THE ADMINISTRATION	- wille	
	This Rule is not met	·		Grower THAT THE		0/-1
		and record review, the e a Resident Register was		LESIDENS REGISTER	2 13	9/3/3
		d within 72 hours of the		PLETED WITHIN	48the	, '
		to the home for 3 of 3		a A RESIDENT MO	note	
	sampled residents (#	1, #2 and #3).		THE ADMINISTRATOR GOVERNE THAT THE LESIDENS REGISTER COMPLETED WITHIN OF A RESIDENT MOT LN TO THE CARE H	pome	
	The findings are:					
	1. Review of Residen	t #1's current FL-2 dated				
		agnosis included diabetes				
		roidism, hypertension, re, bipolar and chronic pain.				
	Review of Resident #	1's Resident Register on				
	08/30/23 at 9:02am re					
	admission date docur page was missing.	mented and the signature				
	Interview with Reside	nt #1 on 08/30/23 at				
		was admitted to the facility				
		did not recall all the papers				

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(X3) DATE SURVEY

COMPLETED

R

08/31/2023

(X5)

COMPLETE

DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: B. WING FCL001184 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C 212 Continued From page 4 C 212 Interview with a medication aide (MA) on 08/31/23 at 11:37am revealed: -She had nothing to do with the Resident Registers; the Administrator did them, -Resident #1 had been at the facility less than a year. Refer to interview with the Administrator 08/30/23 at 11:44am. 2. Review of Resident #2's FL-2 dated 08/09/23 revealed diagnoses included hypertension, coronary artery disease, hyperlipidemia, left ventricular hypertrophy, prediabetes, cervical myopathy, cerebral infarction, edema and mild dementia. Review of Resident #2's Resident Register on 08/30/23 at 1030am revealed there was no admission date documented, it was signed but not dated.

 not dated.

 Interview with Resident #2 on 09/31/23 at

 11:04am revealed:

 -He had been admitted to the facility from a hotel.

 -He did not recall completing paperwork when he

 was admitted.

 -He thought he had been admitted to the facility a

 couple of weeks ago.

 Interview with a medication aide (MA) on

 08/31/23 at 11:37am revealed:

 -She had nothing to do with the Resident

 Registers; the Administrator did them.

 -She thought Resident #2 was admitted to the

 facility about one week ago.

 Refer to interview with the Administrator 08/30/23 at 11:44am.

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If continuation sheet 5 of 37

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED	
		FCL001184	B. WING			R 08/31/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
ELIA 1 FA	MILY CARE HOME		ENDLY ROAD GTON, NC 27217				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE	
C 212	Continued From page	9 5	C 212				
	08/17/23 revealed dia hypertension, chronic gastroesophageal ref Review of Resident # 08/30/23 at 2:42pm re admission date and n documented on the re Interview with Reside 11:04am revealed: -She had been admitt with a family member -She did not know if a completed when she	lux disease (GERD). 3's Resident Register on evealed there was no o signatures or dates egister. nt #3 on 09/31/23 at ed to the facility from a hotel					
	facility about one wee	revealed: o with the Resident strator did them. t #3 was admitted to the					
	Interview with the Adn 11:44am revealed: -He was responsible fi resident's records and to date.	I making sure they were up Resident Registers were not ked at them, but they					

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If continuation sheet 6 of 37

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		FCL001184	B. WING	×	R 08/31/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATI	E, ZIP CODE		
-	MILY CARE HOME	206 FRI	ENDLY ROAD			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLE	
C 270	Continued From page	e 6	C 270			
C 270	10A NCAC 13G .090 Service	4 (c)(7) Nutrition And Food	C 270			
	Menus in Family Car (7) The facility shall h diet menu for any res	4 Nutrition And Food Service e Homes: have a matching therapeutic sident's physician-ordered uidance of food service staff.				
	reviews, the facility fa matching therapeutic guidance when prepa residents who had ph and #2) for a no cond	ns, interviews, and record ailed to ensure there was a diet menu to use for				
	The findings are:					
	revealed: -There was a weekly posted on the wall. -There were no thera	tchen on 08/30/23 at 8:17am menu with regular diets peutic diet menus available when preparing meals.		Type text here		
	02/06/23 revealed: -Diagnosis included of	t #1's current FL-2 dated liabetes mellitus two. for a no concentrated				
	Interview with Reside 10:39am revealed:	nt #1 on 08/30/23 at				

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If continuation sheet 7 of 37

	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE : COMPL		
		FCL001184	B. WING			08/31/2023	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
LIA 1 FA	MILY CARE HOME		ENDLY ROAD GTON, NC 27217				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLE DATE	
C 270	Continued From page	e 7	C 270				
	-He was a sever diab	petic and took several					
	medications for his d						
	-He did not think he v	was ordered any kind of					
	diabetic diet and he v	was not served an NCS diet.					
	Interview with a Med	ication Aide (MA) on					
		evealed Resident #1 was					
		ot eat anything with sugar.					
	Interview with a seco	nd MA on 08/30/23 at					
	2:34pm revealed:						
		a low sugar diet because he					
	had high [blood] suga						
		it was on the regular menu					
	and she didn't put su	gar in his food.					
	Refer to interview wit 08/30/23 at 8:33am.	h a Medication Aide (MA) on					
	Refer to interview wit at 2:34pm.	h a second MA on 08/30/23					
	•	with Resident #1's primary					
	care provider (PCP) o unsuccessful.	on 08/31/23 at 10:25am was					
	2. Review of Residen revealed:	t #2's FL-2 dated 08/09/23					
	-Diagnoses included	hypertension, coronary					
		lipidemia, left ventricular					
		etes, cervical myopathy,					
		dema and mild dementia.					
	- mere was an order t	for a low fat-high fiber diet.					
	Interview with Reside	nt #2 on 09/31/23 at					
	11:04am revealed he	did not think the physician				0	
	had ordered him a the	erapeutic diet.					
	Telephone interview v	vith Resident #2's a					
		ne primary care provider					

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		FCL001184	B. WING			R / 31/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
elia 1 Fa	AMILY CARE HOME		ENDLY ROAD GTON, NC 27217			
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
C 270	Continued From page	9 8	C 270			
	-Resident #2 had not because he was new -If Resident #2 had an fat diet the facility was order until it was char Refer to interview with 08/30/23 at 8:33am. Refer to interview with at 2:34pm. Refer to the interview 08/31/23 at 9:41am. Interview with a Media 08/30/23 at 8:33am reference	n a Medication Aide (MA) on n a second MA on 08/30/23 with the Administrator on cation Aide (MA) on evealed:	58			
	wall.	ekly menu posted on the nenu was the only menu she				
	because none of the r diet order that require	rapeutic menus to follow residents had a therapeutic				
	9:41am revealed: -Resident #1 was orde the other residents we diet. -The therapeutic diet in the kitchen for the stat the office and not in th	ninistrator on 08/31/23 at ered an NCS diet; none of ere ordered a therapeutic menu should have been in ff to reference but it was in the kitchen. d the meal service in about				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R B. WING FCL001184 08/31/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C 270 Continued From page 9 C 270 THE MENT BINDER IS NOW three months, so he was not aware the staff did IN THE KITCHES FOR STARE 9/1/23 not have therapeutic diet menu in the kitchen and were not using it for the diets. -He was not aware Resident #2 had an order for a low fat-high fiber diet. REENDERT #2 DIET HAD BEEN CHARTED BY THE 9/15/23 PCP TO LOW FAT/ LOW -Resident #2 was a new admission and he had not had a chance to completely review the FI-2. -The MAs should have reviewed Resident #2's FL-d and realized he ad a therapeutic diet order. -The facility did not have a low fat-high fiber therapeutic menu and would have to consult with Workspor Die Resident #2's PCP. C 283 C 283 10A NCAC 13G .0904 (e)(3) Nutrition And Food Service The SIC will monitor the kitchen weekly to ensure the 10A NCAC 13G .0904 Nutrition And Food Service therapeutic diet menu is being used Therapeutic Diets in Family Care Homes: by the staff. (3) The facility shall maintain a current listing of $10/27/23 \rho_{T}$ residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observation, record reviews, and interviews, the facility failed to ensure a listing of residents with physician-ordered therapeutic diets was available for the guidance of the facility staff for 1 of 2 sampled residents with an order for a low fat-high fiber diet (#2). The findings are: Review of Resident #2's FL-2 dated 08/09/23 revealed: -Diagnoses included hypertension, coronary

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If continuation sheet 10 of 37

DEFICIENCIES DRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPLE	
	FCL001184			R 08/3	1/2023
	STREET A			•	
JER OR SUPPLIER			ATE, ZIP CODE		
Y CARE HOME			7		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOL	ILD BE	(X5) COMPLETE DATE
ntinued From pag	e 10	C 283			
bertrophy, prediab rebral infarction, en rere was an order servation of the ki realed: here was a diet list chen. he diet list was not idents currently re- hly one resident or rapeutic diet; the ular diets. esident #2 was not serview with a Medi 31/23 at 11:37am he Administrator po- idents. he had net been to he referenced the li- he did not know Re-	etes, cervical myopathy, dema and mild dementia. for a low fat-high fiber diet. tchen on 08/30/23 at 8:17am a posted on the wall in the dated. e residents; only two of the esided in the facility. In the list was ordered a other residents were listed as t on the list. ication Aide (MA) on revealed: posted the diet list for the old to update the list. list every day for changes. esident #2 had an order for a				
2am revealed: e MAs were supp y were supposed ords. e should have che was admitted but e last time he che nths ago. e was not aware or	osed to post the diet list; to reference the resident's cked the list after Resident in had not done it. cked the list was a couple of f Resident #2's diet order for				F
	DER OR SUPPLIER Y CARE HOME SUMMARY ST (EACH DEFICIENC REGULATORY OR Intinued From pag ery disease, hypel betral infarction, e here was an order servation of the ki ealed: here was a diet list here was a diet list idents currently re- hy one resident or rapeutic diet; the or ular diets. beident #2 was not erview with a Med 31/23 at 11:37am the Administrator po- idents. he had net been to be referenced the le did not know Re- fat-high fiber diet erview with the Ad 2am revealed: the Mas were supp y were supposed ords. the had nate che was admitted but the last time he che mths ago. the was not aware or the supposed the supposed th	IDENTIFICATION NUMBER: FCL001184 DER OR SUPPLIER Y CARE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 10 erry disease, hyperlipidemia, left ventricular bertrophy, prediabetes, cervical myopathy, rebrai infarction, edema and mild dementia. iere was an order for a low fat-high fiber diet. servation of the kitchen on 08/30/23 at 8:17am ealed: iere was a diet list posted on the wall in the then. ie diet list was not dated. ie list included five residents; only two of the idents currently resided in the facility. Ny one resident on the list was ordered a rapeutic diet; the other residents were listed as ular diets. enview with a Medication Aide (MA) on 31/23 at 11:37am revealed: ie Administrator posted the diet list for the idents. ie had net been told to update the list. ie referenced the list every day for changes. ie did not know Resident #2 had an order for a fat-high fiber diet. erview with the Administrator on 08/31/23 at 2am revealed: ie MAS were supposed to post the diet list; y were supposed to reference the resident's ords. is should have checked the list after Resident was admitted but in had not done it.	IDENTIFICATION NUMBER: A. BUILDING: FCL001184 B. WING DEER OR SUPPLIER STREET ADDRESS, CITY, ST Y CARE HOME 206 FRIENDLY ROAD BURLINGTON, NC 2721 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ntinued From page 10 C 283 erry disease, hyperlipidemia, left ventricular bertrophy, prediabetes, cervical myopathy, rebrai infarction, edema and mild dementia. Here was an order for a low fat-high fiber diet. servation of the kitchen on 08/30/23 at 8:17am ealed: Here was a diet list posted on the wall in the then. He list included five residents; only two of the idents currently resided in the facility. Tay one resident on the list was ordered a rapeutic diet; the other residents were listed as ular diets. Here had net been told to update the list. Hereforenced the list every day for changes. He dad not know Resident #2 had an order for a fat-high fiber diet. erview with the Administrator on 08/31/23 at 2am revealed: Here supposed to reference the resident's ords. e MAs were supposed to post the diet list; y were supposed to reference the resident's ords. e should have checked the list after Resident was admitted but in had not done it. He last time he checked the list was a couple of nths ago.	DERTIFICATION NUMBER: A. BUILDING: FCL001184 B. WING CARE HOME 206 FRIENDLY ROAD BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAS THE RECORD BY FULL (RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY WAS THE RECORD BY FULL (RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY WAS THE RECORD BY FULL (RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY WAS THE RECORD BY FULL (RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY WAS THE RECORD BY FULL (RECOLLTORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECT (EACH OORRECTWE ACTION SALE) Intitude from page 10 C 283 ID PROVIDER'S PLAN OF CORRECT (EACH OORRECTWE ACTION SALE) erry was a diet list posted on the wall in the idents. ID PROVIDER'S PLAN OF CARE (ID STATE, ZIP CODE erre was a not dr for a low fat-high fiber diet. ID PROVIDER'S PLAN OF CARE (ID STATE, ZIP CODE servation of the kitchen on 08/30/23 at 8:17am ealed: ID PROVIDER'S PLAN OF CARE (ID STATE, ZIP CODE erre was an order for a low fat-high fiber diet. ID PROVIDER'S PLAN OF CARE (ID STATE, ZIP CODE erre was and order to the fist. ID STATE, ZIP CODE erre was and order to diet list. ID STATE, ZIP CARE erre was and inthe Administrator on 08/31/23 at 2am revealed: ID S	INFRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLIA FCL001184 B. WING B. WING B. WING DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 206 FRIENDLY ROAD BURLINGTON, NC 27217 BURLINGTON, NC 27217 PROVIDERS PLAN OF CORRECTION IEACH DEFICIENCY MUST BE PRACEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX and the precedual and the state of the approximate of the approx

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Division (of Health Service Regu	lation			FORM	APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		FCL001184	B. WING		F 08/3	t/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	MILY CARE HOME	206 FRI	ENDLY ROAD			
		BURLIN	GTON, NC 27217			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 330	Continued From page	9 11	C 330			
C 330	10A NCAC 13G .1004 Administration	4(a) Medication	C 330			
	 (a) A family care hom preparation and admi prescription and non-by staff are in accorda (1) orders by a license which are maintained (2) rules in this Section and procedures. This Rule is not met a Based on observation interviews, the facility medications as ordereresidents (#1, and #3) short-acting insulin ar used to control blood medication for hemory. The findings: Review of Resident #02/06/23 revealed an treat diabetes) three to (SS). Review of Resident #01/16/23 revealed the Humalog 100unit/ml was and the source of the sou	ed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: as, record reviews, and failed to administer ed for 2 of 3 sampled) including a fast ad a diabetic medication sugars (#1); and a rhoids (#3). t #1's current FL-2 dated gnosis included diabetes t #1's current FL-2 dated order for Humalog (used to imes daily per sliding scale 1's physician's order dated re was an order for vith food per sliding scale if ar (FSBS) was 150-200=2 s, 251-300=6 units,				

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		FCL001184	B. WING		R 08/31/2023	3
AME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	E, ZIP CODE		
	MILY CARE HOME	206 FRI	ENDLY ROAD			
		BURLIN	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMP THE APPROPRIATE DA	(5) PLETE ATE
C 330	Continued From page	e 12	C 330			
	dated 08/18/23 revea	for Humalog per sliding				
	summary dated 08/18 order for Humalog 10 scale if FSBS was 15	41's after visit physician's 8/23 revealed there was an 00unit/ml with food per sliding 50-200= 4 units, 201-250=8 hits, 301-350=12 units,				
	administration recom -There was an entry sliding scale if finger was 150-200=2 units 251-300=6 units, 30 units scheduled at 8 -There was documen administered three to amounts of Humalog on the MAR. -There was an entry	for Humalog 100unit/ml per stick blood sugar (FSBS) , 201-250=4 units, -350=8 units, 351-400=10 00am, 12:00pm and 5:00pm. tation the Humalog was mes daily; there were no administered documented to check FSBS three times heduled at 7:00am,				
	were checked three t from 08/01/23 to 08/3 FSBS results docume	tation Resident #1's FSBS imes daily before meals 0/23 but there were no ented. nentation of the 08/18/23				
	revealed: -The FSBS log had R Humalog hand writter -There were five wee	'1's August 2023 FSBS log esident #1's name and n across the top of the page, kly blocks on the August block had the day of the				

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING R B. WING 08/31/2023 FCL001184 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **206 FRIENDLY ROAD** ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 330 C 330 Continued From page 13 week from Monday to Sunday and a documented date across in a row. -Each row had a block for the FSBS result, the units of Humalog administered, the time of the day and initials three times daily. -The first block was dated from 07/31/23 to 08/05/23. -There was a sliding scale hand written on the margin of the log beside the first block. -The sliding scale was not dated but was if finger stick blood sugar (FSBS) was 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units, -The second block was dated from 08/07/23 to 08/13/23. -The third block was dated from 08/14/23 to 08/20/23. -There was a second undated sliding scale hand written on the margin beside the third block of the FSBS log; 150-200=4 units, 201-300=8 units, 251-300=10 units, 301-350= 12 units, 351-450= 14 units. -There was a fourth block dated from 08/21/23 to 08/26/23; the last FSBS documented was on 08/26/23 at 7:00am -There was no documentation for Sunday, 08/27/23. -There was a fifth block with only one date and one entry; the date was 08/31/23 at 12:00pm. -On 08/03/23, Resident #1's FSBS was 217 and 2 units of Humalog were documented as administered; per the sliding scale 4 units should have been administered. -On 08/05/23, Resident #1's FSBS was 350 and 10 units of insulin were documented as administered; per the sliding scale 8 units should have been administered. -On 08/09/23. Resident #1's FSBS was 247 and 6 units of insulin were documented as administered; per the sliding scale 4 units should

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Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: R B. WING FCL001184 08/31/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME **BURLINGTON, NC 27217** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 330 C 330 Continued From page 14 have been administered. -On 08/11/23, Resident #1's FSBS was 370 and 8 units of insulin were documented as administered; per the sliding scale 10 units should have been administered. -On 08/20/23, Resident #1's FSBS was 285 and 8 units of insulin were documented as administered; per the sliding scale 10 units should have been administered. -On 08/21/23, Resident #1's FSBS was 137 and 4 Gerea Pous on FSBS 9/3/23 No ENTRE THAF ALL MEDMATIONS ART ADMINISCEED BS FRESCRIBED BY PHE PCP'S. SIC TO FOLION Ateouch THAF THO IS units of insulin were documented as administered; per the sliding scale 0 units should have been administered. -On 08/31/23, Resident #1's FSBS was 227 and 10 units of insulin were documented as administered; per the sliding scale 8 units should have been administered. -Resident #1's FSBS results and Humalog were not documented as administered on his FSBS log AWAYS THE SITUATION. on 13 opportunities from 08/26/23 at 12:00 to 08/31/23 at 7:00am. -There was no documentation of refusals. Observation of Resident #1's medication on hand on 08/30/23 revealed: -Resident #1 had four Humalog pens; two opened in resealable baggies and two unopened together in a box. -The opened pens were not dated with open dates and were in a clear resealable bag with a dispense date on the label of 08/18/23; the sliding scale on the label was 150-200=4 units, 201-300=8 units, 251-300=10 units, 301-350= 12 units, 351-450= 14 units. -One pen had 180mL available for administration and the second pen had 250mL available. Telephone interview with a Pharmacist from the facility's contracted pharmacy on 08/30/23 at 1:14pm revealed:

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING 08/31/2023 FCL001184 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME **BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 330 C 330 Continued From page 15 -Resident #1 had an order for Humalog three times daily per sliding scale. -Resident #1 had a sliding scale order dated 01/16/23 for 150-200=2 units, 201-250=4 units, 251-300=6 units, 301-350=8 units, 351-400=10 units scheduled at 8:00am, 12:00pm and 5:00pm. -Resident #1's sliding scale order for his Humalog was changed on 08/18/23 to 150-200=4 units, 201-300=8 units, 251-300=10 units, 301-350= 12 units, 351-450= 14 units. -Resident #1's was dispensed two Humalog injectable pens on 07/10/23 and 08/14/23 each pen had 300 units. -A label with the new sliding scale order was dispensed on 08/18/23. -Humalog was used to control blood glucose in the blood by lowering the amount of glucose in the blood. -If Humalog sliding scale was not administered correctly the resident could experience increase blood glucose or low blood glucose. -Depending on how high or low the FSBS results were, it could cause hypoglycemia or hypoglycemia and could put the resident in the hospital. Interview with Resident #1 on 08/30/23 at 10:39am revealed: -He was diabetic. -He was on a sliding scale for his insulin three times daily. -He did not know what the units for the sliding scale were. -He thought his FSBS checks were done every day, but he could not be sure. -He did not require Humalog very often because his FSBS results were below 200. -He could not recall what his FSBS results were for this morning, but he thought the FSBS check was done; he did not require an injection at

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R B. WING FCL001184 08/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME **BURLINGTON, NC 27217** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 330 C 330 Continued From page 16 breakfast today, 08/30/23. -The last time he had was administered Humalog was about a week ago. Interview with the medication aide (MA) on 08/30/23 at 3:03pm revealed: -She checked Resident #1's FSBS checks right before he ate his meals. -She used the sliding scale that was on the package and on the FSBS log to administer him his Humalog. -She had been off since the morning of 08/26/23 and had noticed there was no documentation of FSBS results and units administered since she last worked. -She did not notice the FSBS log was not complete until the previous MA had already left EXERA FORMES ON FJBS DE GOSWEG THAT BROOD JUGAR NUMBORS ARE ALLIRAS ENY RECORDED. 9/3/23 EXPERICATED TOAM NONBER HAS BRON ABSIGNED TO THE LICATION JO THAT GRANDARDS ARE IMPROVED. LOSS EXPERIENTED TAM MONBER 11 ND the facility. -She tried to be careful and referenced the log before she dialed the Humalog pen and injected Resident #1. Interview with the Administrator on 08/31/23 at 1:07pm revealed: -The MAs documented the FSBS checks were completed by initialing the MAR. -The MAs were supposed to document FSBS results on the FSBS log after every check. -If Humalog was administered the number of units administered were documented on the log. -The sliding scale was on the medication label and on the FSBS log. -The MAs were supposed to reference the scale TAM MONBER 11 200 Lower ER PART SY DAE TEAM LO DHAT LOCATON to determine the amount of Humalog to inject. -It was very important to carefully follow the sliding scale and document the correct result and the units administered. -The MAs should not get the units injected wrong because they could make the resident sick. -Resident #1 was not compliant with orders and

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: R B. WING FCL001184 08/31/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 330 C 330 Continued From page 17 ate and drank what he wanted so it was even more important to follow the sliding scale correctly and to document correctly. Attempted telephone interview with a second MA on 09/31/23 at aa:32am was unsuccessful. Attempted interview with Resident #1's primary care provider (PCP) on 08/31/23 at 10:25am was unsuccessful. b. Review of Resident #1's physician's order dated 05/22/23 revealed an order for dulaglutide (used to treat diabetes) 0.75mg/0.5mL inject once weekly. Review of Resident #1's physician's order dated 08/21/23 revealed an order for dulaglutide 1.5mg/0.5mL injection once weekly Review of Resident #1's medication administration record (MAR) for July 2023 revealed: -There was an entry for dulaglutide 0.75mg/0.5mL inject once weekly scheduled at 8:00am, -There was documentation dulaglutide was administered on 07/05/23, 07/12/23, 07/19/23 and 07/26/23 at 8:00am. Review of Resident #1's August 2023 MAR at 11:53am revealed: -There was an entry for dulaglutide 0.75mg/0.5mL inject once weekly scheduled at 8:00am. -There was documentation dulaglutide 0.75mg/0.5mL was administered on 08/02/23, 08/09/23, and 08/16/23 at 8:00am. -There was a second-hand written entry for dulaglutide 1.5mg inject once weekly scheduled

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY
		FCL001184	B. WING		R 08/31/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
		206 FRI	ENDLY ROAD			
ELIA 1 FA	AMILY CARE HOME	BURLIN	GTON, NC 27217			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX	· · · · · · · · · · · · · · · · · · ·	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLETI DATE
IAG			ind	DEFICIENC		
C 330	Continued From page	e 18	C 330			
	at 8:00am.					
		tation dulaglutide was				
	administered on 08/2					
		nented dulaglutide was				
	administered on 08/3	0/25 dt 0.00dm.				
	Observation of Resid	ent #1's medication on hand				
		am revealed there were no				
	dulaglutide 0.75mg/0.					
	1.5mg/0.5mL availabl					
	Interview with Reside	nt #1 on 08/30/23 at				
	10:39am revealed:					
	-He was a diabetic.					
		dulaglutide once a week on				
	Wednesdays at break	ministered his dulaglutide				
	today, 08/30/23.	ninistered his dulagidude				
		edication aide (MA) about				
		on and she told him there				
	was not any available					
	-The MA told him it ha	ad been ordered by a				1
	[named] MA a few da	ys ago and would be at the				
	facility today, 08/30/2	3.				8
		vith a Pharmacist from the				
		harmacy on 08/30/23 at				
	1:14pm revealed:					
		utide injection was not on a				
	•	e requested to be refilled by				
	the facility.	eceived a telephone request				
		ill Resident #1's dulaglutide				
	injection.					
	-	dispense the dulaglutide to				
	the facility before the					
		ave called prior to today,				
	-	e dulaglutide pens were				1
1	available for the 8:00a					
	-Dulaglutide was not a	an insulin worked along with				

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		IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A, BUILDING:		R
		FCL001184	B. WING		08/31/2023
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ITE, ZIP CODE	
LIA 1 FA	MILY CARE HOME		ENDLY ROAD GTON, NC 27217	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPL
C 330	insulin to lower bloo -If not administered experience increase Interview with the M revealed: -She had administer dulaglutide injection the last dosage. -She had told anoth pen so he could reo -She did not order m pharmacy. -She had told the M. Resident #1 did not available for his dos -When the dulaglutide she would administer Interview with the Ad 1:50pm revealed: -The dulaglutide inje have been in the fac administration on 08 -The dulaglutide per by the MA before the after the last pen wa -There was plenty of from the pharmacy w injection was admini- He expected the star request the medicative was needed.	d glucose. as ordered the resident could ad blood glucose levels. A on 08/30/23 at 3:03pm red Resident #1 his on 08/23/23 and had used er MA she had used the last rder it from the pharmacy. nedications from the A again today, 08/30/23 that have a dulaglutide pen age for today. de came in today, 08/30/23 that have a dulaglutide pen age for today. de came in today, 08/30/23 at er it to him. dministrator on 08/31/23 at ection for Resident #1 should cility for the scheduled 8:00am should have been ordered e last pen was used or right is administered. f time to order the medication when the last dulaglutide	C 330	Experiences Tor Momber who I PART of Att TEAN Att Stanson WM MAT DI NEORD I ON ANT DI NEORD I ON ANTE. TEAM TO FOLON THRO MANTOR MONT	Im S NOW m JN q/2 m JN
		with Resident #1's primary on 08/31/23 at 10:25am was		Monitor Mons	Huy.

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	ETED
		FCL001184	B. WING		F 08/3	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ELIA 1 FA	MILY CARE HOME		NDLY ROAD GTON, NC 2721	7		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE
C 330	Continued From page	9 20	C 330			
	08/17/23 revealed: -Diagnoses included a -There was an order if (used to shrink hemotiapply to the rectal area Review of Resident # administration record 08/30/23 revealed: -There was an entry f 2.5 percent cream ap daily scheduled at 8:0 -There was document hydrocortisone was a 08/19/23 to 08/30/23; Observation of Reside hand on 08/30/23 at 3 -There was a box of p percent cream dispent -There was an unoper hydrocortisone 2.5 per the foil seal was still if -The unopened tube was administration. -The label from the cord the orders and were of hydrocortisone cream the rectal area once do Telephone interview was facility's contracted ph 10:35am revealed: -Resident #3 had an of hydrocortisone 2.5 per area once daily.	for perianal hydrocortisone rrhoids) 2.5 percent cream ea once daily. 3's August 2023 medication (MAR) from 08/18/23 to or perianal hydrocortisone ply to the rectal area once 00am. tation perianal dministered at 8:00am from a total of twelve days. ent #3's medications on 8:08pm revealed: berianal hydrocortisone 2.5 used on 08/18/23. ned tube of perianal ercent cream inside the box; ntact on the end of the tube. was available for on the box of perianal ; the orders were to apply to laily. with the Pharmacist at the harmacy on 08/31/23 at order for perianal rcent cream apply to rectal msed a tube of perianal		The SIC will monitor monthly by che the box is locked. 10/27/23	cking to ensu	re

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		Ilation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	ETED
		FCL001184	B. WING			x 31/2023
	ROVIDER OR SUPPLIER	206 FRIE	DDRESS, CITY, ST ENDLY ROAD GTON, NC 2721			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 330	-The perianal hydrocochemorrhoids while als -An outcome of not achydrocortisone cream discomfort from swoll Interview with Reside 11:14am revealed: -She had hemorrhoid when she had bowel -She usually applied a when she had a bowel of had the cream sin facility about a week of -She was supposed the hemorrhoids every da -Her hemorrhoids had had been admitted to Telephone interview w Resident #3's primary office on 08/31/23 at -Resident #3 had an of hydrocortisone 2.5 pe daily to the rectal area -The PCP had only se 08/17/23 and had not the visit. -Resident #3 had a pu hydrocortisone cream -The perianal hydrococ on Resident #3's hem -The PCP expected tho orders as written.	ortisone cream was to shrink so providing relief for itching. dministering the perianal n as ordered would be len and itching hemorrhoids. ant #3 on 08/31/23 at is because they protruded movements. a cream for her hemorrhoids el movement, but she had nee she had moved into the or two ago. o apply the cream for her ay. d not bothered her since she the facility. with a representative from y care provider's (PCP's) 11:20am revealed: order for perianal ercent cream apply once a. een Resident #3 once on a creamined the resident at rior order for the n from another PCP. prtisone cream was for use norrhoids. he facility to follow the edication Aide (MA) on	C 330	EXPERIENCED POA MEMBER HAS G MEMBER HAS G MENSER HAS G MESSIDENTS WM ON RESIDENTS WM ON RESIDENTS WM ON CONCERNATION STOTAL WODERS JAC WHAT IS BARCC JACT WHAT IS BARCC	monto BUARMS totte GER THERE FANIME FED. SE DONTO KAROL	9/3/2

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	FCL001184		B. WING		08	R /31/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	MILY CARE HOME	206 FRIE	NDLY ROAD			
		BURLING	GTON, NC 27217			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES A MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
C 330	Continued From page	e 22	C 330			
	was an unopened tu -She followed the orc compared them to the	lers on the medication and				
	1:07pm revealed: -He noticed Resident cream was unopened medication on 08/30/ -He expected the MA medication labels and orders on the MAR w medication. -The PCP had written hydrocortisone cream reason.	is to read the orders on the d compare them to the when administering in the order for the perianal in for Resident #3 for a is to administer medications				
		interview with a second MA am was unsuccessful.				
C 341	10A NCAC 13G .100 Administration	4 (i) Medication	C 341			
	10A NCAC 13G .100	4 Medication Administration				
	medication administra staff person who adm immediately following medication to the res					

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(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: R B. WING FCL001184 08/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME **BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 341 C 341 Continued From page 23 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure documentation of medications including for 2 of 3 residents (#2 and #3) including an anticonvulsant, a medication to prevent heart failure (#2) and diuretics (#3). The findings are: Observation of the facility on 08/30/23 at 8:00am revealed: -There were three residents seated at the dining room table eating breakfast. JTAFF MEANBER HAS BEEN RETRAINED SN PHE NED TO FOLLOW OTHERNAT 9 [3]23 WITH THE REGIST MEDUATION TOMMYDRADIN FROM POLATION DIVE RENDBOT AF A RINE AND DOWNERS AFFER HAS BEEN ADMINISTERED. -The medication aide (MA) sat at one end of the table with a stack of medication cards. -She did not have medication administration records (MAR) at the table. -She was administering medications to two of the residents one at a time by popping the medication from the cards and pouring them into small opaque cups. -She put the medication cards back into the medication room. -She did not document on the MARs for the residents. 1. Review of Resident #2's FL-2 dated 08/09/23 revealed: -Diagnoses included hypertension, coronary artery disease, hyperlipidemia, left ventricular hypertrophy, prediabetes, cervical myopathy, cerebral infarction, edema and mild dementia. -There was an order for gabapentin (used to treat seizures) 300mg one tablet three times daily. Type text here -There was an order for lisinopril (used to prevent heart failure) 40mg one tablet twice daily Division of Health Service Regulation

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: R B. WING 08/31/2023 FCL001184 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 341 C 341 Continued From page 24 Review of Resident #2's Resident Register on 08/30/23 at 1030am revealed there was no admission date documented, it was signed but not dated. Review of Resident #2's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 at 8:49am revealed: -There was an entry for gabapentin 300mg one tablet scheduled three times daily at 8:00am, 2:00pm and 8:00pm. -There was documentation gabapentin was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation gabapentin was administered at 8:00am on 08/30/23. -There was an entry for lisinopril 40mg one tablet scheduled twice daily at 8:00am, and 8:00pm. -There was documentation lisinopril was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation lisinopril was administered at 8:00am on 08/30/23. Observation of Resident #2's medications on hand on 08/30/23 at 11:14am revealed: -Resident #2's medications were dispensed in a multidose bubble packages. -Each bubble listed the medications, the administration time and the administration date. -The 8:00am medications for 08/30/23 had been punched from the bubble; including the gabapentin and the lisinopril. Refer to interviews with the Medication Aide (MA) on 08/31/23 at 12:03pm. Refer to interview with the Administrator on 08/31/23 at 1:20pm. Division of Health Service Regulation

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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: R B. WING FCL001184 08/31/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME **BURLINGTON, NC 27217** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 341 C 341 Continued From page 25 Attempted telephone interview with a second MA on 09/31/23 at aa:32am was unsuccessful. 2. Review of Resident #3's current FL-2 dated 08/17/23 revealed: -Diagnoses included dementia, hypertension, chronic kidney disease, and gastroesophageal reflux disease (GERD). -There was an order for chlorthalidone (a diuretic used to treat fluid retention) 25mg once daily. -There was an order for furosemide (a diuretic used to treat fluid retention) 40mg once daily. Review of Resident #3's Resident Register on 08/30/23 at 2:42pm revealed there was no admission date and no signatures or dates documented on the register. Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 at 8:49am revealed: -There was an entry for chlorthalidone 25mg once daily scheduled at 8:00am. -There was documentation chlorthalidone was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation chlorthalidone was administered at 8:00am on 08/30/23. -There was an entry for furosemide 40mg once daily scheduled at 8:00am. -There was documentation furosemide was administered at 8:00am from 08/19/23 to 08/29/23; a total of eleven days. -There was no documentation furosemide was administered at 8:00am on 08/30/23. Refer to interviews with the Medication Aide (MA) on 08/31/23 at 12:03pm.

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	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
	8	FCL001184	B. WING		R 08/31/2	2023
ELIA 1 FA		206 FRIE	DDRESS, CITY, ST ENDLY ROAD GTON, NC 2721			(УЕ)
(X4) ID PREFIX TAG	(EACH DEFICIENC	A EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
C 341	08/31/23 at 1:20pm. Attempted telephone on 09/31/23 at aa:32a Interview with the Me 08/31/23 at 12:03pm -She documented me the MAR after admini medication one at a ti -She had seen where document administrat residents on 08/30/23 -She called the other administered the me documented her own -The other MA did not administration on the forgot. -She should not have and should have just Interview with the Adr 1:20pm revealed: -The MAs were traine from the card at a tim the MAR. -They were to compare to the MAR prior to pu -They were to watch to medication and then of each administration. -The MA were suppose them while administer -One MA should not of -He had not looked at	in the Administrator on interview with a second MA am was unsuccessful. dication Aide (MA) on revealed: dication administration on stering each resident their me. another MA had not ion of medication for two a t 8:00am. MA and asked if she had lications and she said she red on the MAR; she initials. always document MAR; she sometimes documented on the MAR left the "holes". ninistrator on 08/31/23 at d to punch one medication e and then to document on re the medication in the card unching the card. he resident swallow the document on the MAR after sed to have the MAR with ring the medications. locument for another. the MAR for the residents oked for "holes" in the MAR	C 341	ASTAANMES DONE Redother to bring PAAT NAGY POLOS Photoming which Messicans Doan Peologuess. She TO monsible M Monthly	2	Yu512

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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING FCL001184 08/31/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 350 C 350 10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to ensure an assessment and physician's order was in place for 1 of 3 sampled residents (#3) who self-administered a medication used to support heart health and a rectal laxative suppository. The findings are:

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Division of Health Servert TATEMENT OF DEFICIENCIE ND PLAN OF CORRECTION	S (X1) P	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE S COMPL	
ND PLAN OF CORRECTION		ENTRICATION NOMBER.	A. BUILDING:			
		FCL001184	B. WING	s	F 08/3	२ 81/2023
AME OF PROVIDER OR SUP	PLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
LIA 1 FAMILY CARE HO	ME		ENDLY ROAD GTON, NC 2721	7		
(VA) ID SIII		T OF DEFICIENCIES		PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX (EACH I	DEFICIENCY MUST	BE PRECEDED BY FULL NTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLET DATE
C 350 Continued Fr	om page 28		C 350			
8:43am revea -There was a suppositories in a short tim -There was a suppositories -There was a support hear basket on the Review of Re 08/17/23 reve -Diagnoses in disease and 1 insufficiency. -Resident #3 Review of Re 10:30am reve -Resident #11 not have a da not dated. -There was n record. -There was n order for self- a. Review of Re administration 08/30/23 reve -There was a once daily sci -There was d	aled: In open contain (used to protect (used to protect (sealed contain sealed contain (sealed contain (sealed contain (sealed contain (sealed) (sealed):	e of aspirin (used to ning the blood) in a rent FL-2 dated tia, chronic kidney aortic valve htly confused. ord on 08/30/23 at gister on 08/30/23 did d, it was signed but assessment in the on of a physician's of any medications. current FL-2 dated is an order for aspirin gust 2023 medication from 08/18/23 to rin 81mg one tablet Dam. aspirin was in 08/19/23 to		RENDONS ROUNA 12 DATED AND CARE PLANS HA BEGO INGNED & ADMINITIATOR GOSMEE ALL P REGRIDENTS PIETA PROTESSES AR COMPLETED PL	50	ef 15]2

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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A, BUILDING: _ R B. WING FCL001184 08/31/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 350 C 350 Continued From page 29 Telephone interview with a representative from Resident #3's primary care provider's (PCP's) office on 08/31/23 at 11:20am revealed: -Resident #3 had an order for aspirin 81mg one tablet once daily; it had been ordered by a cardiologist for her heart. -Aspirin was a blood thinner. -Resident #3 had did not have an order to self-administer aspirin. -Resident #3 had not been evaluated for self-administration of any medications, -If Resident #3 was administered two doses of aspirin verse the one tablet her blood could be too thin and make her more susceptible to bruising and possibly bleeding out from a cut or injury. Interview with Resident #3 on 08/31/23 at 11:14am revealed: -She brought the aspirin with her when she was admitted to the facility. -She took the aspirin for her heart. -He physician had told her to take aspirin for her heart. -She had self-administered the medication once a day since she was at the facility. -She did not know if the facility staff knew she had the aspirin in her room, and she was self-administering it. -Aspirin was not dangerous to take so she did not see a problem with having it in her room. -She knew the staff administered her medications, but she did not know what they were or if they administered her an aspirin. Refer to interview with the Medication Aide (MA) on 08/31/23 at 11:37am. Refer to interview with the Administrator on

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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R B. WING 08/31/2023 FCL001184 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME **BURLINGTON, NC 27217** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) C 350 C 350 Continued From page 30 08/31/23 at 1:07pm. b. Review of Resident #3's current FL-2 dated 08/17/23 revealed there was not order for rectal FOTAL FOLMS TO GUILRE THAT MEDILATION'S THAT ARE ADMINISTERED ARE RELORDED ON THE MAR. STRAFF TO LITCHLE & BUSINES THAT THIS IS HAPPENDESS SIL TO MONTHER THIS BUT ONLY laxative suppositories Review of Resident #3's August 2023 medication administration record (MAR) from 08/18/23 to 08/30/23 revealed: -There was an entry for polyethylene glycol 17gm once daily scheduled at 8:00am. -There was documentation polyethylene glycol was administered at 8:00am from 08/19/23 to 08/30/23: a total of twelve days. -There was no entry for rectal laxative suppositories on the MAR. PESCESS. Interview with Resident #3 on 08/31/23 at 11:04am revealed: -She brought the suppositories with her when she was admitted to the facility. -She had trouble with hemorrhoids and constipation. -She used the rectal laxatives about once daily. -She did not know if the facility staff knew she had the laxatives in her room, she did not hide them. -She knew the staff administered her medications. -She did not know if she was administered a laxative by the staff. Telephone interview with a representative from Resident #3's primary care provider's (PCP's) office on 08/31/23 at 11:20am revealed: -Resident #3 had an order for polyethylene glycol 17gm once daily for constipation. -Resident #3 did not have an order for rectal laxatives. -Resident #3 had did not have an order to Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
	S CONNECTION		A, BUILDING:		
		FCL001184	B. WING		R 08/31/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
ELIA 1 FA	MILY CARE HOME		IDLY ROAD TON, NC 2721	7	
(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 APPROPF DEFICIENCY)	BE COMPLETE
C 350	self-administer any la -Resident #3 had not self-administration of -If Resident #3 was a laxative her bowel mo loose and cause deh hemorrhoids to becom Refer to interview with on 08/31/23 at 11:37a Refer to interview with 08/31/23 at 11:37am -None of the resident mediations. -None of the resident rooms. -Residents were not a medications themselve mediations in their roo -She looked around t any over the counter she cleaned their roo -If she found OTC me the Administrator abo -She had never found the residents' rooms. -Resident #3 had an she administered it e -She had not seen ar #3's room. Interview with the Add 1:07pm revealed: -The facility did not h self-administration of	exatives. been evaluated for any medications. dministered too much byements could become too ydration and cause her me irritated. h the Medication Aide (MA) am. h the Administrator on dication Aide (MA) on revealed: s administered their own s kept medications in their allowed to administer ves or to store any oms. he residents' rooms daily for (OTC) medications while ms. edications, she would notify but the medications. d OTC medications in any of order for aspirin once daily; very morning. hy medications in Resident ministrator on 08/31/23 at		MEDIANONS KORED K ACONDENTS LOOM WA MUNICIPATION KONON FROM ATCH KONON RESIDENTS POPS CON AND THESE THESE VILL MONITOR MONTHLY BY AND AND THESE MEDICATOR POPS CON MEDICATOR RECT NEDICATOR RECT NEDICATOR ROTS NEOLULI TO GUIL MAT THERE ADE OVER THE COUNTER MEDICATORS BEN STORED FO ATE ROS ROTORS.	ing to be sure

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	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		RUDVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		FCL001184	B. WING			R 31/2023
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	FE, ZIP CODE		
ELIA 1 FA	MILY CARE HOME	206 FRI	ENDLY ROAD			
			GTON, NC 27217			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
C 350	Continued From page	9 32	C 350			
	facility to have contro -He expected the stat rooms everyday and to notify him if they fo -He was not aware Re in her room including suppositories. 10A NCAC 13G .1006 10a NCAC 13G .1006 (a) Medications that a	nedications; he wanted the I of all medications. If to look in the residents' to look for medications and und any. esident #3 had medications the aspirin and the S (a) Medication Storage S Medication Storage are self-administered and s room shall be stored in a her as specified in the	C 352			
				The SIC will monitor monthly the box is locked. 10/27/23 ed	/ by checking to ens	ure
	interviews, the facility residents' medications secure manner for 1 of	s, record reviews, and failed to ensure that the s were stored in a safe and f 1 sampled resident (#3) ectal laxative suppositories				
	The findings are:					

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Division of	of Health Service Regu	lation				APPROVED
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	
		IDENTIFICATION NOWBER.	A BUILDING:		COMPE	
		FCL001184	B. WING		R 08/3	₹ 1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE		
				,		
ELIA 1 FA	MILY CARE HOME		GTON, NC 27217			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR(DEFICIENCY)		COMPLETE DATE
C 352	Continued From page	ə 33	C 352			
	8:43am revealed: -There was an open of suppositories (used to in a short time) on a t -There was a sealed suppositories in a bas -There was an opene support heart health to basket on the floor. Review of Resident # 08/17/23 revealed: -Diagnoses included of -Resident #3 was inter Refer to interview with 11:04am. Refer to interview with 08/31/23 at 11:37a Refer to interview with 08/31/23 at 1:07pm. a. Review of Resident #2 administration record 08/30/23 revealed: -There was an entry for once daily scheduled -There was document administered at 8:00a 08/30/23; a total of tw	container of rectal laxative sket on the floor. d bottle of aspirin (used to by thinning the blood) in a 3's current FL-2 dated dementia. ermittently confused. In Resident #3 on 08/31/23 at in the Medication Aide (MA) am. In the Medication Aide (MA) am. In the Administrator on t #3's current FL-2 dated ere was an order for aspirin e daily. 3's August 2023 medication (MAR) from 08/18/23 to or aspirin 81mg one tablet at 8:00am. tation aspirin was m from 08/19/23 to				

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	of Health Service Regu				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED
		FCL001184	B. WING		R 08/31/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
-		206 FRIE	ENDLY ROAD		
ELIA 1 FA	MILY CARE HOME	BURLIN	GTON, NC 27217		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO DEFICIEI	D THE APPROPRIATE DATE
C 352	Continued From page	e 34	C 352		
	08/17/23 revealed there was not order for rectal laxative suppositories				
		43's August 2023 medication			
		(MAR) from 08/18/23 to ere was no entry for rectal			
	laxative suppositories				
	Refer to interview wit 11:04am.	h Resident #3 on 08/31/23 at			
	Refer to interview with on 08/31/23 at 11:37a	h the Medication Aide (MA) am.			
	Refer to interview with 08/31/23 at 1:07pm.	h the Administrator on			
	Interview with Reside	nt #3 on 08/31/23 at			
	was admitted to the fa				
		f knew about the om; she did not try to hide			
	them. -She did not have a lo to lock the medication	ock in her room and no way ns up.			
	08/31/23 at 11:37am				
	rooms.	s kept medications in their			
	-Residents were not a mediations in their roo				
		he residents' rooms daily for			
		n she cleaned their rooms.			
	-She had not seen an #3's room.	y medications in Resident			
		ninistrator on 08/31/23 at			
	1:07pm revealed: Ith Service Regulation				

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Division of Health Service Regulation (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING: R B. WING FCL001184 08/31/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX **REGULATORY OR LSC IDENTIFYING INFORMATION)** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 352 C 352 Continued From page 35 -Residents were not allowed to keep medications in their rooms. -He expected the staff to look in the residents' rooms every day for medications and to notify him if they found any. -He was not aware Resident #3 had medications in her room. C 353 10A NCAC 13G .1006 (b) Medication Storage C 353 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications for 1 of 3 residents (#1) were stored in a locked container in the refrigerator. The findings are: Observation of the kitchen on 08/30/23 at 11:23am revealed: -There was no door that lead from the resident dining area to the kitchen. -The refrigerator in the kitchen was not locked. -The refrigerator contained various food items for residents and staff. -There was a drawer in the refrigerator that contained injectable medications. -There were three clear resealable bags each

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with a medication label and an injectable pen; one bag had a used Levemir (used to treat diabetes) pen and two had used Humalog (used to treat

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING: _ R B. WING FCL001184 08/31/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 206 FRIENDLY ROAD ELIA 1 FAMILY CARE HOME **BURLINGTON, NC 27217** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) C 353 C 353 Continued From page 36 diabetes) pen. -There was a box with one unused Levemir pen. -There was a box with three unused Humalog pens. Interview with the Medication Aide (MA) on ALL MEDICATIONS THAT ARE STORED IS THE REFRIGERATION ARE IN A LOURD 08/30/23 at 11:25am revealed the Levemir and Humalog were always kept in the drawer in the refrigerator and were not secured with a lock. 9/2/20 Interview with the Administrator on 08/30/23 at 11:30am revealed: -He was aware medications stored in the refrigerator were supposed to be in secured by a CONANTERlock. -It was an oversite that the medication was not secured by a lock. The SIC will monitor monthly by checking to ensure the box is locked. 10/27/23 ammended Division of Health Service Regulation

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