STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035021	A. BUILDING: _____ B. WING _____	R 11/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE FAMILY CARE HOME III	45 CANNADY WAY FRANKLINTON, NC 27525

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C 000	Initial Comments The Adult Care Licensure Section and the Franklin County Department of Social Services conducted an annual and follow up survey on 10/31/17 and 11/2/17 with an exit conference via telephone on 11/3/17.	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: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to report two low monthly blood pressure readings for 1 of 3 residents (#1) on an antihypertensive medication (Lisinopril)with orders from the Primary Care Provider to report blood pressure readings outside the ordered parameters. The findings are: Review of Resident #1's current FL-2 dated 2/3/17 revealed: -Diagnoses included bipolar disorder, neurocognitive disorder, hypertension and hyperthyroidism. - A Primary Care Provider (PCP) order for monthly blood pressures. -A PCP order for Lisinopril 20mg daily (Lisinopril is used to treat high blood pressure). Review of a PCP prescription order for Resident #1 dated 1/16/17 revealed an order to contact the PCP for blood pressure results less than 90/40 or	C 246		

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C 246	Continued From page 1 greater than 160/100. Review of a PCP prescription order for Resident #1 dated 10/18/17 revealed there was an order to report blood pressure results less than 90/40 or greater than 150/90. Review of Resident #1's July 2017 Medication Administration Record (MAR) revealed: -There was a hand written entry to check blood pressure monthly and call MD if less than 90/40 or greater than 160/100 for advice. -There was documentation on 7/15/17 that the blood pressure was 79/64. Review of Resident #1's August 2017 MAR revealed: -There was a hand written entry to check blood pressure monthly and call MD if less than 90/40 or greater than 160/100 for advice. -There was documentation on 8/15/17 that the blood pressure was 86/65. Review of Resident #1's September 2017 MAR revealed: -There was a hand written entry to check blood pressure monthly and call MD if less than 90/40 or greater than 160/100. -There was documentation on 9/15/17 that the blood pressure was 109/78. Review of Resident #1's October 2017 MAR revealed: -There was a hand written entry to check blood pressure monthly and call MD if less than 90/40 or greater than 160/100. -There was documentation on 10/15/17 that the blood pressure was 98/51. Review of Resident #1's July, August, September	C 246		

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and October 2017 MARs revealed the Lisinopril 20mg was documented as administered daily as ordered by the PCP.

Interview with Resident #1 on 10/31/17 at 2:46pm revealed:
-He had been sick for the past four days with diarrhea.
-Staff had taken him to the emergency room.
-He could not remember which day he went to the emergency room.
-He was able to walk to a church nearby, but was no longer able to walk to the church by himself.
-He had started to get tired when he walked to church and would lay down along the way on the grass.
-After he rested for a few minutes, he would walk the rest of the way to the church.
-He did not know if his doctor knew about his fatigue.
-He could not remember when he saw his doctor, but thought he may have had an appointment coming up soon.

Review of a "Work/School Note" from the hospital for Resident #1 dated 10/27/17 revealed there was documentation Resident #1 was "seen and treated in the emergency department on 10/27/17."

Telephone interview with Resident #1's family member on 10/31/17 at 5:34pm revealed:
-She visited Resident #1 about every three to four weeks.
-Resident #1 had gotten to where he could not get out of the car and into a store before needing to sit down and rest.
-She felt some of the resident's medications might be affecting his ability to walk.
-The staff at the facility contacted her whenever

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C 246	Continued From page 3 there was a problem. -The staff at the facility had discussed concerns related to Resident #1's fatigue with the resident's PCP. -She did not know exactly when staff had discussed concerns with the PCP. Review of Resident #1's record revealed there was no documentation the resident's PCP was notified of the 7/15/17 blood pressure result of 79/64 and the 8/15/17 blood pressure result of 86/55. Observations on 11/2/17 from 10:45am until 11:15am revealed: -Resident #1 was seated on the sofa in the common area. -Resident #1 was drowsy, had slurred speech and drifted off in the middle of talking. -Resident #1 had significant weakness and was unable to stand and walk to the kitchen area to get his blood pressure checked. -The Supervisor in Charge (SIC) brought the electronic blood pressure cuff into the common area to check Resident #1's blood pressure. -The first three attempts to check Resident #1's blood pressure resulted in an error code on the machine. -The SIC dropped the blood pressure machine between each recheck because the outlet cord for the blood pressure did not allow the blood pressure cuff to reach close enough to the resident. -The fourth blood pressure check showed a result of 115/77. -The Administrator arrived at the facility at 10:55am to take Resident #1 to the PCP's office. -The Administrator called the emergency medical system (EMS) for Resident #1 to go to the emergency room.	C 246		

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C 246	Continued From page 4 - The EMS technician's checked Resident #1's blood pressure at approximately 11:05am and the result was 71/40. Interview with the SIC on 11/2/17 at 10:45am revealed: -Resident #1 was "like this" meaning tired, weak and having slurred speech on 11/1/17. -The Administrator had contacted the PCP on 11/1/17 and the resident had an appointment to see the PCP at 11:00am on 11/2/17. Interview with the Administrator on 11/2/17 at 10:55am revealed: -Resident #1 had been out of the facility with the Administrator all day on 11/1/17. -He had seen that Resident #1 had increased weakness and contacted the PCP on 11/1/17. -Resident #1 had an appointment with the PCP on 11/2/17 at 11:00am. -He called EMS because resident #1 was too weak and unable to stand. -Resident #1 needed to be taken to the emergency room (ER) by ambulance. -He thought Resident #1's medications "might be too much for him." Interview with a second SIC on 10/31/17 at 4:34pm revealed: -The SIC was responsible for contacting a resident's PCP and documenting any contact in the resident's record. -She had notified Resident #1's PCP of the low blood pressure result in July and August when she had checked the blood and the result was low (7/15/17 and 8/15/17). -She notified the PCP by fax and there should have been documentation in the resident's record. -She would have to check the backup file for	C 246		

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C 246	Continued From page 5 copies of the fax confirmations that were sent to the PCP for Resident #1's low blood pressures on 7/15/17 and 8/15/17 because she did not see any documentation in the resident's record. -The usual process when a resident's blood pressure was low was to wait 15 minutes and recheck the blood pressure and if the blood pressure remained low, the SIC would fax a notification to the PCP and write please advise. -The PCP would write a comment on the fax notification and fax the form back to the facility and the return fax from the PCP was filed in the resident's record. Interview with the second SIC on 10/31/17 at 4:51pm revealed: -She could not find the fax notifications for the low blood pressure results on 7/15/17 and 8/15/17 for Resident #1 in his backup file either. -Resident #1 had gotten to where he could not walk long distances; she had notified the PCP and an order (10/18/17) was written for the resident to have a walker. -Resident #1 was no longer able to walk to church by himself because he would stop and sit down on the grass. Telephone interview with Resident #1's PCP on 11/2/17 at 11:00am revealed: -Staff at the facility had not reported any low blood pressure results for Resident #1. -Staff at the facility "were not good about reporting any concerns" related to the residents. -She expected to be contacted when the blood pressure was outside the written parameters and/or if there were changes in the resident's condition. -She needed to end the interview and return to seeing patients.	C 246		

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C 246	Continued From page 6 Interview with the Administrator on 11/2/17 at 4:30pm and 11/3/17 at 11:47am revealed: -Resident #1 had been admitted to the hospital on 11/2/17 and diagnosed with pneumonia. -He and the staff had reported Resident #1's diarrhea and weakness to the PCP and took the resident to the ER on 10/27/17 where he was diagnosed with gastritis. -He and the staff needed to be better about documenting communication with the PCP when there were concerns about a resident's condition. -He was planning a meeting the weekend of 11/4/17 to review reporting and documentation expectations with staff and the facility nurse. -Staff were expected to report blood pressure results to the PCP and make sure to document in the resident's record. The facility's failure to report three low monthly blood pressure readings for Resident #1 who was on antihypertensive medication (Lisinopril) and had orders from the Primary Care Provider to report blood pressure readings outside the ordered parameters was detrimental to the health and safety of Resident #1 by increasing the risk of symptomatic low blood pressure (fatigue, weakness and dizziness) and risk of hospitalization, which constitutes a Type B Violation. Review of the Plan of Protection submitted by the facility on 11/2/17 revealed: -The SIC will notify [the PCP] of the condition of the resident upon the resident not feeling well. -The SIC will fax [results outside the ordered] parameters of [residents'] vital signs and keep record of the fax [communication] with the [PCP] office. -The Administrator will [monitor] weekly to ensure communication with PCP [when indicated] and	C 246		

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C 246	Continued From page 7 [documentation] is kept in the [residents'] records of communication with the [PCP]. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 18, 2017.	C 246		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to administer triamterene/hydrochlorothiazide (an antihypertensive and diuretic medication) as ordered by the Primary Care Provider for 1 of 3 residents (#3) for 27 days. The findings are: Review of Resident #3's current FL-2 dated 1/19/17 revealed: -Diagnoses included obesity, gastro-esophageal reflux disease, chronic obstructive pulmonary disease and paranoid schizophrenia. -There was an order for triamterene/hydrochlorothiazide 37.5/25mg daily (Triamterene/hydrochlorothiazide is used to treat high blood pressure and edema.)	C 330		

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C 330	Continued From page 8 Review of subsequent orders for Resident #3 revealed: -On 6/22/17 there was a prescription order for triamterene/hydrochlorothiazide 37.5/25mg daily as needed for edema. -On 10/18/17 there was a prescription order for triamterene/hydrochlorothiazide 37.5/25mg daily. Interview with Resident #3 on 11/2/17 at 4:20pm revealed: -She had swelling in both of her legs from her ankles to her knees. -The swelling was worse in her left leg than her right leg. -She had the swelling for about four months. -The swelling would go away for a couple days and then come back. Review of Resident #3's October 2017 Medication Administration Record (MAR) revealed: -There was a preprinted entry for triamterene/hydrochlorothiazide 37.5/25mg daily as needed for edema. -There were no doses documented as having been administered. -There was no entry for triamterene/hydrochlorothiazide 37.5/25mg daily. Review of Resident #3's November 2017 MAR revealed: -There was a preprinted entry for triamterene/hydrochlorothiazide 37.5/25mg daily. -There was documentation doses were administered on 11/1/17 and 11/2/17 at 8:00am. Observation of medications on hand for Resident #3 on 11/2/17 at 10:31am revealed: -There was a bubble pack with a pharmacy label	C 330		

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C 330	Continued From page 9 which included Resident #3's name and instructions for triamterene/hydrochlorothiazide 37.5/25mg daily. -The pharmacy label indicated 30 tablets were dispensed on 10/3/17 and there were 29 tablets remaining. Interview with the Supervisor in Charge (SIC) on 11/2/17 at 12:48pm and 3:30pm revealed: -Resident #1 had a PCP office visit on 10/3/17 and the PCP sent the new orders directly to the pharmacy by electronic prescriptions. -The facility did not have the prescription orders dated 10/3/17 for Resident #3. -The facility had received a new bubble pack of triamterene/hydrochlorothiazide for Resident #3 on 10/3/17, but there was already an order for PRN so the SIC did not question receiving the new bubble pack. -The PCP changed the order for the triamterene/hydrochlorothiazide from as needed (PRN) to scheduled. -The facility did not receive a copy of the electronic prescription sent to the pharmacy on 10/3/17 by the PCP's office. -The facility had been waiting for the orders from the PCP since Resident #3 was seen on 10/3/17. -The Administrator had to go to the PCP's office and pick up the prescriptions last week (10/26/17) and those were the prescription orders dated 10/18/17 in Resident #3's record. -She did not know what day the Administrator went to the PCP's office to pick up the prescriptions. -The facility had discussed the need for copies of all orders for residents with the PCP several times. -Any new orders were faxed to the pharmacy and documented on the MAR. -The PCP also sent prescription orders directly to	C 330		

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C 330	Continued From page 10 the pharmacy. -Medications were usually delivered to the facility within 24 hours of the order being sent to the pharmacy. -The SIC removed the refill sticker from the bubble pack, placed the sticker on an order form and faxed the order form to the pharmacy to request refills. -If the SIC did not request refills, the pharmacy would not fill and send refills. Telephone interview with the facility's contracted pharmacy on 11/2/17 at 3:00pm revealed: -Triamterene/hydrochlorothiazide was dispensed on 8/4/17 for a 30 day supply of 30 tablets for Resident #3. -The order on 8/4/17 was for triamterene/hydrochlorothiazide daily as needed. -There was an order on 10/3/17 for triamterene/hydrochlorothiazide daily and a 30 day supply of 30 tablets were dispensed on 10/3/17 for Resident #3. -The triamterene/hydrochlorothiazide had not been dispensed between 8/4/17 and 10/3/17. -The pharmacy received orders from the facility via fax and electronic prescription orders from the PCP's office. -There was an online portal available for facilities to view PCP orders. -She did not have the ability to see if the facility had a log in or if the facility had reviewed orders online. Based on observation of medications on hand, interviews and review of PCP orders and MARs, Resident #1 did not receive triamterene/hydrochlorothiazide 37.5/25mg daily as ordered by the PCP from 10/4/17 through 10/31/17 (27 doses).	C 330		

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C 330	Continued From page 11 Interview with the Administrator on 11/2/17 at 4:30pm revealed: -He was frustrated with electronic prescription orders and the lack of effective communication about the orders from the PCP to the facility. -He planned to work with the pharmacy and PCP to develop a process to ensure copies of electronic prescriptions were sent to the facility. -He planned to have the SIC create a log in for the online portal to the pharmacy so the SIC could review orders weekly.	C 330		