STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041031	A. BUILDING: _____ B. WING _____	09/09/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CJR FAMILY CARE HOME	809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/05/19 and 09/06/19 with a telephone exit on 09/09/19.	C 000		
C 207	10A NCAC 13G .0702(c)(4) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient, the administrator or supervisor-in-charge shall contact the physician for clarification in order to determine if the services of the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure a diet order was indicated on the current FL2 for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 01/14/19 revealed: -Diagnoses included chronic obstructive pulmonary disease, seizure disorder, lung mass, anemia, chronic aspiration, history of cerebrovascular accident, and history of chronic kidney disease stage III. -Under nutritional status the word "Diet" was circled but there was nothing written beside it.	C 207		

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C 207	Continued From page 1 Observation of lunch meal service on 09/05/19 at 11:45 am revealed: -Resident #3 was served a ham and cheese sandwich with lettuce, tomato and mayonnaise on white bread with a small bag of plain chips. -The resident was served a glass of water and a cup of cola. -Resident #3 ate 100% of the meal. Observation of lunch meal service on 09/06/19 at 12:25 pm revealed: -Resident #3 was served baked beans with wieners, a salad with ranch dressing, 1 slice of white bread, sugar free lime jello, a glass of water, a glass of milk and a glass of cola. -Resident #3 ate 100% of his meal. Interview with Resident #3 on 09/05/19 at 11:44 am revealed he could eat what he wanted to because he was not on any diet. Interview with a medication aide (MA) on 09/05/19 at 2:40 pm revealed: -She did not know residents were supposed to have a diet order. -She assumed that all the residents were on a regular diet. -She did not review the residents' FL2s or any notes the physician wrote for their diets because she was not trained to do so. -It was the Administrator's responsibility to inform her if anyone was on a special diet. Interview with the Administrator on 09/06/19 at 3:00 pm revealed: -She did not know Resident #3 did not have a diet order on his FL2. -She was responsible for ensuring each resident had a diet order.	C 207		

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C 207	Continued From page 2 -She was responsible for processing the diet orders on the FL2. -She had not reviewed any resident records or FL2s in several months because she had been busy with other things. -It was her responsibility to ensure each resident records, including diet orders were correct. Telephone interview with Resident #3's primary care physician on 09/09/19 at 10:48 am revealed: -He did not usually write a diet order on the FL2. -Resident #3 was on a regular diet.	C 207		
C 283	10A NCAC 13G .0904 (e-3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Therapeutic Diets in Family Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain a therapeutic diet list for guidance of food service staff for 1 of 3 residents sampled (#1), who had an order for a diabetic diet. The findings are: 1. Review of Resident #1's current FL2 dated 02/25/19 revealed: -Diagnoses included bipolar disorder, depression,	C 283		

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C 283	Continued From page 3	C 283		

diabetes mellitus, arthritis, gastroesophageal reflux disorder, and hypertension.
-There was an order for a diabetic diet which was no concentrated sweets (NCS).

Observation during the facility tour on 09/05/19 between 11:30 am - 11:45 am revealed there was no therapeutic diet list posted.

Observation of lunch meal service on 09/05/19 at 11:45 am revealed:
-Resident #1 was served a ham and cheese sandwich with lettuce, tomato and mayonnaise on white bread with a small bag of plain chips.
-The resident was served a glass of water, and a cup of diet cola.
-Resident #3 ate 100% of his meal.

Observation of lunch meal service on 09/06/19 at 12:25 pm revealed:
-Resident #1 was served baked beans with wieners, a salad with ranch dressing, 1 slice of white bread, sugar free lime jello, a glass of water and a glass of diet cola.
-Resident #1 ate 100% of his meal.

Interview with Resident #1 on 09/05/19 at 11:40 am revealed the resident declined to be interviewed.

Interview with the Medication Aide (MA) on 09/05/19 at 2:40 pm revealed:
-She did not know Resident #1 was on an NCS diet.
-She did not know there was supposed to be a diet list posted in the facility.
-She prepared breakfast lunch and dinner at the facility.
-She thought all the residents were on a regular diet.

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C 283	Continued From page 4 -It was the Administrator's responsibility to inform her if anyone was on a special diet. Interview with the Administrator on 09/06/19 at 3:00 pm revealed: -She knew Resident #1 was ordered an NCS diet. -She was responsible for creating and updating a diet list based on the diet orders. -It was her responsibility to ensure staff were aware of any therapeutic diets ordered by the physician. -She had not reviewed any resident records for diet orders in several months because she had been busy with other things. -She had not made a therapeutic diet list for staff recently.	C 283		
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 assure medications were administered as ordered for 2 of 3 residents sampled (#2, #3) including an anti-anxiety, antipsychotic medications, an anticholinergic, and a statin medication (Resident #2); and a vitamin B1 supplement (Resident #3).	C 330		

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C 330	Continued From page 5 The findings are: 1. Review of Resident #2's current FL2 dated 07/29/19 revealed diagnoses included schizoaffective disorder, bipolar type substance disorder, anxiety, Vitamin D deficiency, hypertension, and lithium induced hypothyroidism. a. Review of Resident #2's current FL2 dated 07/29/19 revealed: -There was an order for Clonazepam (used to treat anxiety) 1 mg twice daily. Review of Resident #2's physician's orders dated 04/04/19 revealed there was an order for Clonazepam 0.5 mg twice daily. Review of Resident #2's physician's orders dated 07/18/19 revealed: - There was an order to discontinue clonazepam 0.5 mg twice daily. - There was an order for Clonazepam 1 mg twice daily. Observation of Resident #2's medications on hand on 09/05/19 at 4:35 pm revealed Clonazepam 1 mg was available for administration and was included in Resident #2's blister packs. Review of Resident #2's July 2019 medication administration record (MAR) revealed: -There was an entry for Clonazepam 0.5 mg twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There was a handwritten "discontinue 07/18/19" across the center of the entry for clonazepam. -Clonazepam was documented as administered twice daily from 07/01/19 - 07/31/19.	C 330		

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C 330	Continued From page 6 Review of Resident #2's August 2019 MAR revealed: -There was an entry for Clonazepam 1 mg twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -Clonazepam was documented as administered twice daily from 08/01/19 - 08/31/19. Interview with Resident #2 on 09/05/19 at 4:00 pm revealed: -The medication aide administered his medications. -They were packaged all together in a blister pack. Interview with the MA on 09/06/19 at 3:10 pm revealed: -Resident #2's medications were in a blister pack. -She did not know if or when Resident #2 had been given new prescriptions. Interview with the Administrator on 09/06/19 at 2:50 pm revealed: -She knew Resident #2's medications had been changed. -Resident #2's medications had been changed monthly for the past 3 months. -She chose to use the current supply of blister packs for Resident #2 until they ran out. -She did not have time to go by the pharmacy to get Resident #2's medications repackaged when they were changed. Telephone interview with the contracted pharmacy representative on 09/09/19 at 12:10 pm revealed Resident #2's medications had been changed monthly for the past 3 months but they did not know of the changes until the prescription hard copies were brought in.	C 330		

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C 330	Continued From page 7 Telephone interview with Resident #2's physician on 09/09/19 at 12:15 pm. -He did not know the facility had not taken the prescriptions to the pharmacy to be filled after he gave them to Resident #2. -He was slowly trying to stabilize Resident #2. -He did not send electronic prescriptions to the pharmacy; he only wrote hard copies. -He expected prescriptions to be changed when written, not 2-3 weeks later. -He expected medications to be administered as ordered. Refer to the interview with a medication aide (MA) on 09/06/19 at 3:15 pm. Refer to the interview with the Administrator on 09/06/19 at 3:00 pm. b. Review of Resident #2's current FL2 dated 07/29/19 revealed: -There was an order for Clozapine (an antipsychotic used to treat schizoaffective disorder) 100 mg every morning. -There was an order for Clozapine (used to treat schizoaffective disorder) 150 mg every night at bedtime. Review of Resident #2's physician's orders dated 04/04/19 revealed there was an order for Clozapine 100 mg every night at bedtime. Review of Resident #2's physician's orders dated 07/18/19 revealed: -There was an order to discontinue Clozapine 100 mg every night at bedtime. -There was an order for Clozapine 100 mg every morning and 150 mg every night at bedtime.	C 330		

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C 330	Continued From page 8 Observation of Resident #2's medications on hand on 09/05/19 at 4:35 pm revealed: -Clozapine 100 mg was included in Resident #2's medication blister pack for the am. -Clozapine 150 mg was included in Resident #2's medication blister pack for the pm. Review of Resident #2's July 2019 medication administration record (MAR) revealed: -There was an entry for Clozapine 100 mg twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -There was a handwritten "discontinue 07/18/19" across the center of the entry for clozapine. -Clozapine was documented as administered twice daily from 07/01/19 - 07/31/19. Review of Resident #2's August 2019 MAR revealed: -There was an entry for Clozapine 100 mg every morning and 150 mg every night at bedtime with a scheduled administration time of 8:00 am and 8:00 pm. -Clozapine was documented as administered every morning and every night at bedtime from 08/01/19 - 08/31/19. Interview with Resident #2 on 09/05/19 at 4:00 pm revealed: -The medication aide administered his medications. -They were packaged all together in a blister pack. Interview with the MA on 09/06/19 at 3:10 pm revealed: -Resident #2's medications were in a blister pack. -She did not know if or when Resident #2 had been given new prescriptions.	C 330		

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C 330	Continued From page 9 Interview with the Administrator on 09/06/19 at 2:50 pm revealed: -She knew Resident #2's medications had been changed. -Resident #2's medications had been changed monthly for the past 3 months. -She chose to use the current supply of blister packs for Resident #2 until they ran out. -She did not have time to go by the pharmacy to get Resident #2's medications repackaged when they were changed. Telephone interview with the contracted pharmacy representative on 09/09/19 at 12:10 pm revealed Resident #2's medications had been changed monthly for the past 3 months but they did not know of the changes until the prescription hard copies were brought in. Telephone interview with Resident #2's physician on 09/09/19 at 12:15 pm. This needs to be under Resident #3 -He did not know the facility had not taken the prescriptions to the pharmacy to be filled after he gave them to Resident #2. -He was slowly trying to stabilize Resident #2. -He did not send electronic prescriptions to the pharmacy; he only wrote hard copies. -He expected prescriptions to be changed when written, not 2-3 weeks later. -He expected medications to be administered as ordered. Refer to the interview with a medication aide (MA) on 09/06/19 at 3:15 pm. Refer to the interview with the Administrator on 09/06/19 at 3:00 pm. c. Review of Resident #2's current FL2 dated	C 330		

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C 330	Continued From page 10 07/29/19 revealed there was an order for benztropine (an anticholinergic used to treat symptoms of Parkinson's disease) 2 mg every night at bedtime. Review of Resident #2's physician's orders dated 07/18/19 revealed there was an order for benztropine 2 mg every night at bedtime. Review of Resident #2's physician's orders dated 08/22/19 revealed: -There was an order to discontinue benztropine 2 mg every night at bedtime. -There was an order for benztropine 1 mg every night at bedtime. Observation of Resident #2's medications on hand on 09/06/19 at 4:35 pm revealed benztropine 2 mg was included in Resident #2's medication blister pack for bedtime. Review of Resident #2's July 2019 MAR revealed: -There was an entry for benztropine 2 mg every night at bedtime with a scheduled administration time of 8:00 pm. -Benztropine was documented as administered nightly from 07/01/19 - 07/31/19. Review of Resident #2's August 2019 MAR revealed: -There was an entry for benztropine 2 mg every night at bedtime with a scheduled administration time of 8:00 pm. -Benztropine was documented as administered nightly from 08/01/19 - 08/31/19. Review of Resident #2's September 2019 MAR revealed: -There was an entry for benztropine 2 mg every night at bedtime with a scheduled administration	C 330		

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C 330	Continued From page 11	C 330		

time of 8:00 pm.
-Benztropine was documented as administered nightly from 09/01/19 - 09/05/19.

Interview with Resident #2 on 09/05/19 at 4:00 pm revealed:
-The medication aide administered his medications.
-They were packaged all together in a blister pack.

Interview with the MA on 09/06/19 at 3:10 pm revealed:
-Resident #2's medications were in a blister pack.
-She did not know if or when Resident #2 had been given new prescriptions.

Interview with the Administrator on 09/06/19 at 2:50 pm revealed:
-She knew Resident #2's medications had been changed.
-Resident #2's medications had been changed monthly for the past 3 months
-She chose to use the current supply of blister packs for Resident #2 until they ran out.
-She did not have time to go by the pharmacy to get Resident #2's medications repackaged when they were changed.

Telephone interview with the contracted pharmacy representative on 09/09/19 at 12:10 pm revealed:
-The pharmacy did not know Resident #2's medications had been changed.
-The last prescriptions they received was on 09/05/19 included a hard copy for benztropine 1 mg at bedtime.

Telephone interview with Resident #2's physician on 09/09/19 at 12:15 pm.

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C 330	Continued From page 12 -He did not know the facility had not taken the prescriptions to the pharmacy to be filled after he gave them to Resident #2. -He was slowly trying to stabilize Resident #2. -He did not send electronic prescriptions to the pharmacy; he only wrote hard copies. -He expected prescriptions to be changed when written, not 2-3 weeks later. -He expected medications to be administered as ordered. Refer to the interview with a medication aide (MA) on 09/06/19 at 3:15 pm. Refer to the interview with the Administrator on 09/06/19 at 3:00 pm. d. Review of Resident #2's current FL2 dated 07/29/19 revealed there was an order for Quetiapine (an antipsychotic used to treat schizoaffective and bipolar disorder) 100 mg twice daily. Review of Resident #2's physician's orders dated 07/18/19 revealed there was an order for quetiapine 100 mg twice daily. Review of Resident #2's physician's orders dated 08/22/19 revealed there was an order for quetiapine 100 mg every night at bedtime. Observation of Resident #2's medications on hand on 09/06/19 at 4:35 pm revealed: -Quetiapine 100 mg was included in Resident #2's medication blister pack for the am. -Quetiapine 100 mg was included in Resident #2's medication blister pack for the pm. Review of Resident #2's July 2019 MAR revealed: -There was an entry for quetiapine 100 mg twice	C 330		

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C 330	Continued From page 13 daily with a scheduled administration time of 8:00 am and 8:00 pm. -Quetiapine was documented as administered twice daily from 07/01/19 - 07/31/19. Review of Resident #2's August 2019 MAR revealed: -There was an entry for quetiapine 100 mg twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -Quetiapine was documented as administered twice daily from 08/01/19 - 08/31/19. Review of Resident #2's September 2019 MAR revealed: -There was an entry for quetiapine 100 mg twice daily with a scheduled administration time of 8:00 am and 8:00 pm. -Quetiapine was documented as administered twice daily from 09/01/19 - 09/05/19. Interview with Resident #2 on 09/05/19 at 4:00 pm revealed: -The medication aide administered his medications. -They were packaged all together in a blister pack. Interview with the MA on 09/06/19 at 3:10 pm revealed: -Resident #2's medications were in a blister pack. -She did not know if or when Resident #2 had been given new prescriptions. Interview with the Administrator on 09/06/19 at 2:50 pm revealed: -She knew Resident #2's medications had been changed. -Resident #2's medications had been changed monthly for the past 3 months.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041031	A. BUILDING: _____ B. WING _____	09/09/2019

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C 330	Continued From page 14 -She chose to use the current supply of blister packs for Resident #2 until they ran out. -She did not have time to go by the pharmacy to get Resident #2's medications repackaged when they were changed. Telephone interview with the contracted pharmacy representative on 09/09/19 at 12:10 pm revealed: -The pharmacy did not know Resident #2's medications had been changed. -The last prescriptions they received was on 09/05/19 included a hard copy for quetiapine 100 mg at bedtime. Telephone interview with Resident #2's physician on 09/09/19 at 12:15 pm. -He did not know the facility had not taken the prescriptions to the pharmacy to be filled after he gave them to Resident #2. -He was slowly trying to stabilize Resident #2. -He did not send electronic prescriptions to the pharmacy; he only wrote hard copies. -He expected prescriptions to be changed when written, not 2-3 weeks later. -He expected medications to be administered as ordered. Refer to the interview with a medication aide (MA) on 09/06/19 at 3:15 pm. Refer to the interview with the Administrator on 09/06/19 at 3:00 pm. e. Review of Resident #2's current FL2 dated 07/29/19 revealed: -There was an order for atorvastatin (a statin medication used to treat high cholesterol) 20 mg every night at bedtime with a scheduled administration time of 8:00 pm.	C 330		

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C 330	Continued From page 15 Observation of Resident #2's medications on hand on 09/06/19 at 4:35 pm revealed atorvastatin 20 mg was included in Resident #2's medication blister pack for bedtime. Review of Resident #2's July 2019 MAR revealed: -There was an entry for atorvastatin 20 mg every night at bedtime with a scheduled administration time of 8:00 pm. -Atorvastatin was documented as administered nightly from 07/01/19 - 07/31/19. Review of Resident #2's August 2019 MAR revealed: -There was no entry for atorvastatin on the August 2019 MAR for Resident #2. Review of Resident #2's September 2019 MAR revealed: -There was an entry for atorvastatin 20 mg every night at bedtime with a scheduled administration time of 8:00 pm. -Atorvastatin was documented as administered nightly from 09/01/19 - 09/05/19. Interview with Resident #2 on 09/05/19 at 4:00 pm revealed: -The medication aide administered his medications. -They were packaged all together in a blister pack. Interview with the MA on 09/06/19 at 3:10 pm revealed: -Resident #2's medications were in a blister pack. -She did not know if or when Resident #2 had been given new prescriptions. Interview with the Administrator on 09/06/19 at	C 330		

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C 330	Continued From page 16 2:50 pm revealed: -She knew Resident #2's medications had been changed. -Resident #2's medications had been changed monthly for the past 3 months. -She chose to use the current supply of blister packs for Resident #2 until they ran out. -She did not have time to go by the pharmacy to get Resident #2's medications repackaged when they were changed. Telephone interview with the contracted pharmacy representative on 09/09/19 at 12:10 pm revealed Resident #2 had used all his refills for atorvastatin and had to get a new prescription. Telephone interview with Resident #2's physician on 09/09/19 at 12:15 pm. -He did not know the facility had not taken the prescriptions to the pharmacy to be filled after he gave them to Resident #2. -He was slowly trying to stabilize Resident #2. -He did not send electronic prescriptions to the pharmacy; he only wrote hard copies. -He expected prescriptions to be changed when written, not 2-3 weeks later. -He expected medications to be administered as ordered. Refer to the interview with a medication aide (MA) on 09/06/19 at 3:15 pm. Refer to the interview with the Administrator on 09/06/19 at 3:00 pm. 2. Review of Resident #3's current FL-2 dated 11/12/18 revealed: -Diagnoses included chronic obstructive pulmonary disease, seizure disorder, lung mass, anemia, chronic aspiration, history of	C 330		

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C 330	Continued From page 17 cerebrovascular accident, and history of chronic kidney disease stage III. -There was an order for thiamine (a supplement used to treat vitamin B 1 deficiency) 100 mg daily. Review of Resident #3's July, August and September 2019 Medication Administration Records (MARs) revealed there was no entry for thiamine 100 mg. Observation of Resident #3's medications on hand on 09/06/19 at 9:45 am revealed there was not any thiamine 100 mg available for administration. Interview with Resident #3 on 09/05/19 at 11:44 am revealed: -He received his medications when they were due. -There had not been any problems with his medications. Interview with a medication aide on 09/05/19 at 2:40 pm revealed: -She did not know Resident #3 had an order for thiamine. -She had never administered thiamine to Resident #3. -She routinely administered medications to Resident #3. Interview with the Administrator on 09/06/19 at 3:00 pm revealed: -She did not know that Resident #3 had an order for thiamine 100 mg since he was admitted and had not received it. -She believe she overlooked the thiamine order for Resident #3. -She had not reviewed Resident #3's orders or record in several months.	C 330		

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C 330	Continued From page 18 -It was her responsibility to ensure each resident record, including medications were correct. -She expected medications to be given as ordered by the physician. Telephone interview with a pharmacist from the contracted pharmacy on 09/06/19 at 1:45 pm revealed: -They did not fill any prescriptions for Resident #3 until January 2019. -Thiamine was not on Resident #3's pharmacy profile as they did not have a record of the order. -They had never dispensed thiamine for Resident #3. -The pharmacy did not use the FL2 as a prescription to fill and dispense medications. Interview with Resident #3's primary care physician (PCP) on 09/09/19 at 10:57 am revealed: -Resident #3 was ordered thiamine due to his alcohol abuse. -He did not know Resident #3 did not receive his thiamine as ordered. -Thiamine would help prevent any alcohol related encephalopathy if Resident #3 continued to drink alcohol. Refer to the interview with a medication aide (MA) on 09/06/19 at 3:15 pm. Refer to the interview with the Administrator on 09/06/19 at 3:00 pm. _____ Interview with the MA on 09/06/19 at 3:15 pm revealed: -She used the medication administration record (MAR) when she passed medications to the residents. -She did not review the residents FL2 or any	C 330		

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C 330	Continued From page 19 orders the physician wrote because she was not trained to do so. -The Administrator reviewed physician orders and the FL2 and made any needed changes to the MAR's. Interview with the Administrator on 09/06/19 at 3:00 pm revealed: -She was responsible for reading FL2's and physician notes and making needed changes to the MAR. -She was responsible for ensuring all residents had their prescribed medications in the home. -She was responsible for ensuring all residents received medications as ordered by a physician.	C 330		