STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032062	A. BUILDING: _____ B. WING _____	R 10/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B J'S FAMILY CARE HOME	716 HUGO STREET DURHAM, NC 27704

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C 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-up survey on October 8, 2019.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician notification for 1 of 3 sampled residents (Resident #1) related to fingerstick blood sugars not obtained twice a day as ordered and needed an order for a new glucometer. The findings are: Review of Resident #1's current FL2 dated 10/16/18 revealed: -Diagnoses included type II diabetes with insulin dependency and paranoid schizophrenia. -There was an order to check finger stick blood sugars (FSBS's) twice a day. Review of Resident #1's signed physician's orders dated 04/26/19 revealed there was an order to check FSBS's twice a day. Review of Resident #1's August 2019 Medication Administration Record (MAR) revealed: -There was an entry for FSBS twice a day at 8:00 am and 4:00 pm. -FSBS results were documented twice a day from 08/01/19 through 08/31/19.	C 246		

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C 246	Continued From page 1 Review of Resident #1's September 2019 MAR revealed: -There was an entry for FSBS twice a day at 8:00 am and 4:00 pm. -There were no FSBS results documented twice a day from 09/01/19 through 09/30/19. -There was no documentation on the MAR why there were no FSBS results. Review of Resident #1's October 2019 MAR revealed: -There was an entry for FSBS twice a day at 8:00 am and 4:00 pm. -There were no FSBS results documented twice a day from 10/01/19 through 10/07/19. -There was no documentation on the MAR why there were no FSBS results. Interview on 10/08/19 at 1:00 pm with a medication aide (MA)/Supervisor-in-Charge (SIC) revealed: -He knew Resident #1 had an order to check FSBS's twice a day. -He knew Resident #1's glucometer had quit working. -He told the Administrator that Resident #1's glucometer had quit working on 09/01/19. -He thought the FSBS's were being completed at Resident #1's day program because the physician wanted him to learn to check his own FSBS. -The primary care physician had asked if the day program could teach him how to check his own FSBS. -The day program had checked Resident #1's FSBS once before. Interview with the Administrator on 10/08/19 at 4:45 pm revealed: -She knew Resident #1's glucometer had quit working at the beginning of September.	C 246		

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C 246	Continued From page 2	C 246		

-Resident #1 was not on a sliding scale insulin, but was on a long acting insulin.
-Resident #1 was supposed to be taught to check his own FSBS at the day program he attended.
-She did not replace Resident #1's glucometer because the facility did not have the funds to do so.
-She had not contacted Resident #1's primary care physician of the need for a new glucometer because she was waiting for insurance to approve a new glucometer.
-She did not let the primary care physician know that Resident #1 was not receiving FSBS checks twice a day as ordered.
-She was responsible for ensuring that residents had equipment that worked properly.
-She was responsible for ensuring that residents received FSBS as ordered by the primary care physician.

Attempted telephone interview with a representative from Resident #1's day program on 10/08/19 at 12:07 pm was unsuccessful.

Interview with Resident #1's primary care physician on 10/08/19 at 1:30 pm revealed:
-There was an order to check Resident #1's FSBS twice a day.
-He did not know Resident #1's FSBS were not being done twice a day.
-He had not been informed that Resident #1's glucometer quit working.
-He had not been informed that Resident #1 needed a new glucometer.
-The day program was supposed to help teach Resident #1 to check his FSBS.
-Not checking Resident #1's FSBS could have led to excessively high blood sugar or excessively low blood sugars.
-He expected the facility to notify him immediately

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C 246	Continued From page 3 if they were not able to check Resident #1's FSBS so he could adjust his insulin dosage to help prevent a hypoglycemic episode.	C 246		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the accuracy of the Medication Administration Records (MARs) for 1 of 3 sampled residents (#2) related to the documentation of the administration of an antipsychotic. The findings are:	C 342		

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C 342	Continued From page 4 Review of Resident #2's current FL2 dated 06/12/19 revealed: -Diagnoses included schizophrenia and diabetes type II. -There was an order for fluphenazine (an antipsychotic used to treat schizophrenia) 5 mg daily. Review of Resident #2's July 2019 medication administration record (MAR) revealed: -All entries were hand written. -There was an entry for fluphenazine 5 mg daily scheduled for 5:00 pm. -There was documentation fluphenazine 5 mg was administered from 07/01/19 to 07/31/19 at 5:00 pm. Review of Resident #2's August 2019 MAR revealed: -All entries were hand written. -There was not an entry for fluphenazine 5 mg daily. Review of Resident #2's September 2019 MAR revealed: -All entries were hand written. -There was not an entry for fluphenazine 5 mg daily. Review of Resident #2's October 2019 MAR revealed: -All entries were hand written. -There was an entry for fluphenazine 5 mg daily scheduled for 6:00 pm. -There was documentation fluphenazine 5 mg was administered from 10/01/19-10/07/19 at 6:00 pm. Observation of medications available for	C 342		

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administration on 10/08/19 at 12:25 pm revealed:
-Fluphenazine 5 mg was available and was prepackaged in blister packs for Resident #2.
-Fluphenazine 5 mg 30 tablets were last dispensed on 10/04/19.

Interview with Resident #2 on 10/08/19 at 3:15 pm revealed he received all his medications, including fluphenazine as ordered.

Interview with a representative at the contracted pharmacy on 10/08/19 at 4:15 pm revealed:
-Fluphenazine 5 mg had been filled monthly and prepackaged with the Resident #2's other medications in blister packs.
-Fluphenazine (5 mg) 30 tablets was dispensed on 07/05/19, 08/08/19, 09/05/19, and 10/04/19.

Interview on 10/08/19 at 1:00 pm with a medication aide (MA)/Supervisor-in-Charge (SIC) revealed:
-He had not passed medications to Resident #2.
-The Administrator usually administered medications to the residents.
-The Administrator transcribed medications onto the MAR's.

Interview with the Administrator on 10/08/19 at 4:45 pm revealed:
-Resident #2's fluphenazine came prepackaged with his other medications in a blister pack.
-Resident #2 received all his medications as ordered.
-She must have forgotten to transcribe fluphenazine onto the August and September MAR for Resident #2.
-She did not complete MAR audits to ensure all medications were listed on the MAR.
-It was her responsibility to ensure the MAR's were accurate.

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