STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL043034	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE FAMILY CARE HOME	431 JUNNY ROAD ANGIER, NC 27501

(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 completed an Annual survey on March 10, 2020 and March 11, 2020 and a telephone exit on March 12, 2020.	C 000		
C 247	10A NCAC 13G .0902(c) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the physician was notified for 2 of 3 sampled residents when the weight loss for one week was greater than or equal to 3 pounds (Resident #2) and refusal to wear TED hose to further prevent the progression of bilateral lower extremity edema (Resident #1). The findings are: 1. Review of Resident #2's current FL2 dated 07/25/19 revealed: -Diagnoses included failure to thrive, dementia, psychosis, depression, anxiety, insomnia, hypertension, glaucoma, coronary artery disease, gastroesophageal reflux, and cardiomyopathy. -There was a physician's order to check weekly weights and notify the physician if Resident #2	C 247		

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C 247	Continued From page 1 lost 3 pounds or more. Review of Resident #2's electronic Medication Administration Record (eMAR) for March 2020 revealed: -There was a computer-generated entry to check weight once every week for monitoring and notify the physician if resident loses 3 pounds or more. -There was a weight documented as 125.8 pounds on 03/02/20 at 8:00am. -There was a weight documented as 118 pounds on 03/09/20 at 8:00am. -There was no documentation on the eMAR the physician was notified of a 7.8-pound weight loss in one week. Review of Resident #2's record revealed there was no documentation the physician had been notified of the 7.8-pound weight loss in one week. Interview with the Medication Aide (MA) on 03/10/20 at 3:13pm revealed: -The third-shift MA performed the task of weighing Resident #2 on 03/09/20 at 8:00am. -She worked as the MA on first shift 03/09/20. -She was not aware Resident #2 had lost 7.8-pounds in one week since she was not the person that weighed Resident #2. -She did not call Resident #2's physician to notify him of the 3 pounds or greater weight loss in one week. -She did not know if the third-shift MA called to notify the physician of Resident #2's weight loss. -The process for notifying physicians was for the MA that performed the task to call when the weight loss was outside of the parameters ordered. -The notification to physicians was supposed to be documented in the Care Notes.	C 247		

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C 247	Continued From page 2 Interview with the Co-Administrator on 03/10/20 at 4:08pm revealed: -The facility did not have a policy regarding notifying the physician of vital signs or weights outside of parameters ordered by the physician. -The MA's were responsible for weighing Resident #2 weekly and recording the weight on the eMAR. -If Resident #2's weight loss was 3 pounds or greater in one week, the MA that weighed Resident #2 was responsible for notifying the physician and recording the notification in the Care Notes. Review of a physician's order for Resident #2 dated 03/11/20 provided by the Co-Administrator revealed: -The physician's order was dated 03/11/20 at 9:23am but was not signed by a physician. -There was a physician's order to discontinue calling the physician for weights over or under 3 pounds effective 12/28/19 for Resident #2. A second interview with the Co-Administrator on 03/11/20 at 12:11pm revealed: -Resident #2 had an order in December 2019 to discontinue notifying the physician of a 3 pound or more weight loss. -She did not know where the order was to discontinue notifying the physician of a 3 pound or more weight loss since the order was not in Resident #2's record. Telephone interview with the Hospice Registered Nurse (RN) on 03/11/20 at 12:20pm revealed: -The Co-Administrator called her on 03/10/20 and informed her Resident #2 had orders for weights twice per week and asked if the order could be discontinued to notify the physician of a weight loss of 3 pounds or more.	C 247		

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C 247	Continued From page 3 -The physician had not reviewed or electronically signed the order for Resident #2. 2. Review of Resident #1's current FL2 dated 10/10/19 revealed: -Diagnoses included major depressive disorder with psychosis, hypertension, hypokalemia, hyperlipidemia, gout, renal disorder and a history of an abdominal hernia. Observation on 03/10/20 at 10:30am and again at 12:00pm revealed Resident #1 was not wearing TED hose. Observation on 03/11/20 at 9:00am revealed Resident #1 was not wearing TED hose. Review of the Physician's orders for Resident #1 revealed: -An order was written on 11/21/20 for TED Hose to be applied daily for lower extermity edema. -There were no orders to discontinue the TED hose for Resident #1. Review of the electronic medication administration record (eMAR) notes for February 2020 revealed: -There was documentation Resident #1 had refused her TED hose on 02/11 at 8am, 02/12 at 8pm, 02/13 at 8pm, 02/17 at 8pm, 02/21 at 8am, 02/21 at 8pm, 02/22 at 8am, 02/22 at 8pm, 2/23 at 8pm, 02/25 at 8am and 02/26 at 8am. Review of the facility medication administration policy revealed: -Refusals were to be documented on the MAR. -Additionally refusal's could be documented by external notes or in the nursing notes section of the residents record.	C 247		

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C 247	Continued From page 4 -Counsel resident. -Attending physician shall be notified after 3 refusals. Review of Resident #1's record revealed: -There was no record of staff providing counsel to Resident #1 per facility policy. -There was no record of staff notifying the attending physician after 3 refusals per facility policy. -There was no documentation in the Nurses Notes reguading Resident #1 refusing her TED hose. Interview with Resident #1 on 03/11/20 at 9:00am revealed: -She had not refused to wear her TED hose. -Staff were not putting her TED hose on because she was getting creams applied to her legs. Interview with the medication aide (MA) on 03/10/20 at -She had not notified the attending physician of Resident #1 refusing her TED hose. -She had not counseled the resident regarding the importance of wearing her TED hose. Interview with the Co-Administrator on 03/11/20 at 2:00pm revealed: -There was no documentation the physician had been notified about any refusals regarding the TED hose. -She did not have an order for the TED hose to be discontinued.	C 247		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the	C 249		

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C 249	Continued From page 5	C 249		

following in the resident's record:
(3) written procedures, treatments or orders from a physician or other licensed health professional; and
(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.

This Rule is not met as evidenced by:
Based on observation, interviews and record reviews the facility failed to implement a physicians order for compression stockings for 1 of 3 residents (Resident#1).

The findings are:

Review of Resident #1's current FL2 dated 10/10/19 revealed:
-Diagnoses included major depressive disorder with psychosis, hypertension, hypokalemia, hyperlipidemia, gout, renal disorder and a history of an abdominal hernia.
-Resident #1 was semi-ambulatory.

Review of the Physician's orders for Resident #1 revealed:
-An order written on 11/21/20 for TED Hose to be applied daily.
-There were no orders to discontinue the TED hose.

Observation on 03/10/20 at 10:30am and again at 12:00pm revealed Resident #1 was not wearing TED hose.

Observation on 03/11/20 at 9:00am revealed Resident #1 was not wearing TED hose.

Review of Resident #1's January 2020 electronic

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C 249	Continued From page 6	C 249		

medication administration record (eMAR) revealed:
-There was a computer-generated entry for applying knee hi TED hose in the morning at 8:00am and remove them in the evening at 8:00pm.
-Ted hose were documented as applied 31 times from 01/01/20-01/31/20.

Review of Resident #1's February 2020 eMAR revealed:
-There was a computer-generated entry for applying knee hi TED hose in the morning at 8:00am and remove them in the evening at 8:00pm.
-Ted hose were documented as applied 18 times from 02/01/20-0/29/20.
-There was no documentation of Resident #1's TED hose being applied on 02/14 and 02/16 but there was documentation the TED hose were removed at 8pm by staff on 02/14 and 02/16.
-There was documentation Resident #1 had refused her TED hose on 02/11 at 8am, 02/12 at 8pm, 02/13 at 8pm, 02/17 at 8pm, 02/21 at 8am, 02/21 at 8pm, 02/22 at 8am, 02/22 at 8pm, 2/23 at 8pm, 02/25 at 8am and 02/26 at 8am.

Review of Resident #1's March 2020 eMAR revealed:
-There was a computer-generated entry for applying knee hi TED hose in the morning at 8:00am and remove them in the evening at 8:00pm.
-Ted hose were documented as applied 9 times from 3/1-3/11 at 8am.
-Ted hose were documented as refused on 03/05 and 03/06 at 8am.
-Ted hose were documented as removed on 03/05 and 03/06 at 8pm.

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C 249	Continued From page 7 Interview with Resident #1 on 03/10/20 at 12:00pm revealed: -She had TED hose available for her to wear. -She was supposed to be wearing her TED hose daily because of the swelling in her legs. -She had not been wearing her TED hose because staff was applying cream to a rash on her legs. -She did not remember refusing to wear her TED hose. Interview with a medication aide (MA) on 03/10/20 at 3:30pm revealed: -Resident #1 did have TED hose she was supposed to wear for the swelling of her legs. -She had not assisted Resident #1 in applying her TED hose on 03/10/20 as she expected the resident to put them on if she wanted to wear them. -She had initialed on the eMAR incorrectly that resident she had applied Resident #1's TED hose on 3/1, 3/2, 3/3 and 3/10. -She had not seen Resident #1 with her TED hose on in 2-3 weeks. Interview with the Co-Administrator on 03/10/20 at 2:00pm revealed: -Before the nurse practitioner (NP) leaves the facility orders were given to the MA. -Orders were put into a follow-up bin and sent to the pharmacy. -The pharmacy placed the orders in the eMAR system for the MA's to document. -The MA's would document on the eMar when a medication or treatment was administered. -She would review the medication with the eMAR and the original order to ensure everything was correct. -She recalled that Resident #1 did not want to wear her TED hose.	C 249		

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C 249	Continued From page 8 -She did not have any documentation the physician or the NP was notified of any refusals nor did she have any documentation the order for TED hose had been discontinued. Interview with a represenative with the facility's contract pharmacy on 03/11/20 at 9:33am revealed: -The pharmacy had received the order and measurements for TED hose on 12/04/19. -The TED hose were received by the facility on 12/04/19. -The pharmacy had a current order for TED hose and had not received any orders for the TED hose to be discontinued. Interview with a second MA on 03/11/20 at 11:20am revealed: -Third shift was responsible for applying TED hose for Resident #1. -She confirmed her initials on the eMAR dated 03/11/20 at 8:00am. -She did not recall applying the TED hose for Resident #1. Interview with the Administrator on 03/11/20 at 3:35pm revealed: -She thought the TED hose had been discontinued as Resident #1 had a rash on her legs. -Resident #1 had told her she did not want to wear the TED hose. -She expected Resident #1 to put on her TED Hose if she wanted to wear them. -"We didn't write the order at the time", but she had obtained an order from the facility's nurse practioner that the TED hose were discontinued back to when the rash back was developed. Interview with the facility's nurse practitioner on	C 249		

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C 249	Continued From page 9 03/11/20 at 4:07pm revealed: -Resident #1 was having swelling in her lower extremities. -She later changed the order to TED hose. -Resident #1 was "doing great" wearing her TED hose as she was having less swelling. -She remembered telling staff to stop applying the TED hose but she had not written an order to discontinue TED hose at that time. -She could not remember when or whom she had told to stop applying the TED hose. -She had spoken with the Administrator earlier this afternoon and had written an order for the TED hose to be discontinued. -She was not aware of any issues with swelling and felt her edema was being controlled.	C 249		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) A family care home shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter;	C 252		

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C 252	Continued From page 10 (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers, up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections as stated in Rule .1004(q) of this Subchapter; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph (14) of this Paragraph); (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy;	C 252		

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C 252	Continued From page 11 (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises; (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure a quarterly Licensed Health Professional Support (LHPS) evaluation had been completed by an appropriate licensed health professional for 1 of 3 sampled residents (Resident #1) for TED Hose. The findings are: Review of Resident #1's current FL2 dated 10/10/19 revealed: -Diagnoses included major depressive disorder with psychosis, hypertension, hypokalemia, hyperlipidemia, gout, renal disorder and a history of an abdominal hernia. -Resident #1 was semi-ambulatory. Review of Resident #1's assessment and care plan dated 10/24/19 revealed no documentation of TED hose. Review of the Physician's orders for Resident #1 revealed:	C 252		

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C 252	Continued From page 12 -A order was written on 11/21/20 for TED hose to be applied daily for lower extermity edema. -There were no orders to discontinue the TED hose for Resident #1. Review of an LHPS assessment for Resident #1 dated 11/22/19 revealed: -There was no task for TED hose ordered 11/21/19. -There was no task documented on the LHPS assessment. Review of the January 2020 electronic Medication Administration Record for Resident #1 revealed there was documentation staff assisted resident with putting on TED hose for Resident #1 in the morning and removing the TED hose in the evening. Review of the February 2020 electronic Medication Administration Record for Resident #1 revealed there was documentation staff assisted resident with putting on TED hose for Resident #1 in the morning and removing the TED hose in the evening. Review of the March 2020 electronic Medication Administration Record for Resident #1 revealed there was documentation staff assisted resident with putting on TED hose for Resident #1 in the morning and removing the TED hose in the evening. Interview with a medication aide (MA) on 03/10/20 at 3:30pm revealed: -Resident #1 did have TED hose she was supposed to wear for the swelling of her legs. -She was not responsible for the LHPS assessment. -The Administrator was responsible for getting the	C 252		

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C 252	Continued From page 13 LHPS assessments completed. Interview with the co-Administrator on 03/10/20 at pm revealed: -She was responsible for making sure the LHPS was completed for residents. -She was responsible for notifying the pharmacy for any new LHPS task and the pharmacy nurse would come out and do the assessment. -She did not have an LHPS completed for Resident #1 because she was not aware of any LHPS task for Resident #1.	C 252		
C 257	10A NCAC 13G .0904(a)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food being stored in the kitchen refrigerator/freezer was protected from contamination related to expired and spoiled food items. The findings are: Observation of the refrigerator/freezer in the facility kitchen on 03/10/20 at 10:07am revealed: -There was celery lying on the 2nd shelf in the refrigerator black in color. -There was a plastic container ¼ full of green grapes in the refrigerator with no expiration date and some of the grapes were rotten.	C 257		

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ABSOLUTE CARE FAMILY CARE HOME	431 JUNNY ROAD ANGIER, NC 27501

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C 257	Continued From page 14 -There was a plastic three-compartment bowl containing peas, macaroni and cheese, and beef with carrots not labeled or dated on the shelf in the refrigerator. -There was half of a 4-pound roll of Canadian bacon loosely wrapped in plastic wrap in the freezer with no date. -There was a package of ham hocks in the door of the freezer with no expiration date and freezer burnt. -There was an orange colored bag in the bottom drawer of the freezer that contained a gallon-sized zip lock bag with frozen, whole fish. Interview with the cook on 03/10/20 at 11:35am revealed: -She would check every 2 to 3 days in the refrigerators at each facility to see what food and drinks needed to be restocked and the expiration dates. -She did not know the exact date she had last checked the refrigerator and freezer at this facility. -Staff at the facility were responsible for labeling and dating any food placed in the refrigerator. Interview with the Co-Administrator on 03/10/20 at 4:08pm revealed: -The cooks were responsible for making sure the refrigerators and freezers were clean and the food had not expired. -The third shift Medication Aide (MA) was responsible for taking everything out of the refrigerator and cleaning the inside on Tuesdays and signing a Staff Cleaning List sheet posted by the time clock. -The Staff Cleaning List was not signed by the MA on 03/10/20 that the refrigerator was cleaned for the week of 03/09/20 through 03/15/20. -She did not know there was rotten food in the	C 257		

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C 257	Continued From page 15 refrigerator. -She did not know there was food items in the freezer that were not stored properly, labeled or dated, and freezer burnt. -She did not know who placed the fresh-caught frozen fish in the freezer. -She was unsure how recently the refrigerator and freezer had been checked for expired or spoiled food items. -She did not have a system in place to check dates on items that were currently open in the refrigerator.	C 257		
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 review, the facility failed to ensure medications were administered as ordered by the physician for 1 of 3 sampled residents (Resident #2) related to a medication used to treat constipation and another medication applied topically for skin breakdown. The findings are: Review of Resident #2's current FL2 dated	C 330		

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C 330	Continued From page 16 07/25/19 revealed diagnoses included failure to thrive, dementia, psychosis, depression, anxiety, insomnia, hypertension, glaucoma, coronary artery disease, gastroesophageal reflux, and cardiomyopathy. A. Review of an electronically signed physician's order for Resident #2 dated 01/06/20 revealed lactulose 5 milliliters (ml) by mouth daily for constipation. Review of Resident #2's January 2020 eMAR revealed: -There was a computer-generated entry for lactulose 15ml by mouth daily. -There was no documentation lactulose 15ml was administered to Resident #2 from 01/06/20-01/31/20. Review of Resident #2's February 2020 eMAR revealed: -There was a computer-generated entry for lactulose 15ml by mouth daily. -Lactulose was documented as administered from 02/01/20-02/15/20 and 02/17/20-02/29/20. - There was no documentation lactulose 15ml was administered to Resident #2 on 02/16/20. Review of Resident #2's March 2020 eMAR revealed: -There was a computer-generated entry for lactulose 15ml by mouth daily. -Lactulose 15ml was documented as administered from 03/01/20-03/10/20. Observation of the medications on hand for Resident #2 on 03/11/20 at 11:43am revealed a partially used bottle of lactulose dispensed by the facility's contracted pharmacy on 02/29/20.	C 330		

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C 330	Continued From page 17 Interview with the MA on 03/11/20 at 11:43am revealed she did not know why lactulose was not administered to Resident #2 for the month of January 2020. Telephone interview with a representative from the facility's contracted pharmacy on 03/11/20 at 12:49pm revealed: -The order for Resident #2's lactulose was faxed to the pharmacy on 01/30/20 and dispensed on 01/31/20 in the amount of 473ml and it would last approximately 30 days. -Resident #2's lactulose had last been dispensed on 02/29/20 in the amount of 473ml and it would last approximately 30 days. -They did not receive a fax from the facility for the lactulose ordered on 01/06/20 electronically signed by the Hospice physician for Resident #2. Attempted telephone interview with Resident #2's Hospice physician on 03/11/20 at 1:44pm was unsuccessful. Telephone interview with the Hospice Registered Nurse (RN) on 03/11/20 at 1:44pm revealed: -Lactulose was ordered for Resident #2 on 11/04/19 due to pain and constipation. -Lactulose should have been administered to Resident #2 the whole month of January 2020. -There was no stop date for lactulose for Resident #2. -Complications from not receiving lactulose for Resident #2 could lead to fecal impaction, hemorrhoids, anal fissures, rectal prolapse, or increased abdominal pain. Interview with the Co-Administrator on 03/11/20 at 2:23pm revealed: -Hospice faxed medication orders for Resident #2 to the facility's contracted pharmacy.	C 330		

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C 330	Continued From page 18 -The MA was responsible for requesting resident's medications to be dispensed by the pharmacy. -She was responsible for reviewing and clarifying all physician orders and made sure they were listed on the eMAR correctly. -She did not know why the pharmacy had blacked out the lactulose on the eMAR for Resident #2 for the month of January 2020. -She did not call to clarify why lactulose was not available on the eMAR to administer to Resident #2. -The facility had a Medication Administration Policies and Procedures system in place and the MA should have called the facility's contracted pharmacy to have the lactulose dispensed when it was ordered on 01/06/20. B. Review of a signed physician's order for Resident #2 dated 01/06/20 revealed zinc oxide ointment, one application four times a day to buttocks. Review of Resident #2's March 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for zinc oxide ointment apply topically to buttocks four times a day for treatment/protection at 7:00am, 11:00am, 4:00pm, and 8:00pm. -Zinc oxide ointment was documented as applied on 03/11/20 at 7:00am and 11:00am. Observation of the medications on hand on 03/11/20 at 11:43am revealed there was no zinc oxide available for administration. Interview with the Medication Aide (MA) on 03/11/20 at 11:43am revealed she thought Resident #2's zinc oxide was in his room at the	C 330		

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C 330	Continued From page 19 bedside. Observation of the MA on 03/11/20 at 11:43am revealed: -She went to Resident #2's room to look for zinc oxide but did not find any. -She asked Resident #2 if his "creams" were in his room and he replied "no, they packed it up" with his former roommate's items when he had moved out. Interview with the MA on 03/11/20 at 11:45am revealed: -She had applied zinc oxide topically to Resident #2 at 7:00am and 11:00am on 03/11/20. -Resident #2 had a small medicine cup in his room with the zinc oxide ointment in it that she had used to apply it to his buttocks on 03/11/20. -She did not know what had happened to the small medicine cup for Resident #2 containing zinc oxide. Interview with Resident #2 on 03/11/20 at 12:10pm revealed: -The facility had not applied zinc oxide ointment to his buttocks since his roommate had moved out about a week ago and they packed it with his belongings. -The last time zinc oxide was applied to his buttocks was about a week ago when the Hospice Certified Nurses Assistant (CNA) visited and assisted him with a bath. -The MA did not apply zinc oxide to his buttocks at 7:00am or 11:00am on 03/11/20. Telephone interview with the Hospice Registered Nurse (RN) on 03/11/20 at 12:20pm revealed: -Resident #2 was receiving Hospice care services twice per week for failure to thrive but he had improved and was decreased to once per week.	C 330		

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C 330	Continued From page 20 -Hospice did not supply Resident #2's zinc oxide barrier ointment. -Zinc oxide was last applied by the Hospice CNA on 02/29/20 when she assisted Resident #2 with a bath. -Zinc oxide was listed on the Hospice Plan of Care for Resident #2 to apply four times per day. Telephone interview with a representative from the facility's contracted Pharmacy on 03/11/20 at 12:49pm revealed: -They had not dispensed zinc oxide for Resident #2. -Zinc oxide was listed on Resident #2's profile but the facility had not requested for it to be dispensed. Interview with the MA on 03/11/20 at 1:50pm revealed: -She had applied zinc oxide stored in a medicine cup to Resident #2 on 03/11/20 at 7:00am. -She did not apply zinc oxide to Resident #2 at 11:00am. -She "clicked" all the medications and documented zinc oxide as applied by accident and needed to remove the 11:00am entry on 03/11/20 from the eMAR system. -The process for administering medications to residents was to administer the medication and then sign the eMAR. -The eMAR would "trigger" the medications due and she would sign all medications. -If she did not administer a medication, she would go back into the eMAR system and remove her signature but sometimes she "forgets, like today" and leaves the medication documented as administered. Interview with the Co-Administrator on 03/11/20 at 2:23pm revealed:	C 330		

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C 330	Continued From page 21 -Hospice faxed medication orders for Resident #2 to the facility's contracted pharmacy. -The MA was responsible for requesting resident's medications to be dispensed by the pharmacy. -The facility had Medication Administration Policies and Procedures and she expected staff to follow them when administering medication. -The MA was supposed to administer the medications to the residents and document on the eMAR the medications that were administered. -She did not know why the MA had signed on the eMAR that zinc oxide was applied to Resident #2 when the medication was not available.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (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	C 342		

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documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the electronic Medication Administration Records (eMAR) were accurate and complete for 2 of 3 sampled residents related to a medication applied topically for skin breakdown (Resident #2) and TED hose to further prevent progression of edema in the lower extremities (Resident #1).

The findings are:

1. Review of Resident #2's current FL2 dated 07/25/19 revealed:
-Diagnoses included failure to thrive, dementia, psychosis, depression, anxiety, insomnia, hypertension, glaucoma, coronary artery disease, gastroesophageal reflux, cardiomyopathy.
-He was incontinent of bladder at times.

Review of a signed physician's order for Resident #2 dated 01/06/20 revealed zinc oxide ointment, one application four times a day to buttocks.

Review of Resident #2's January 2020 eMAR revealed:
-There was a computer-generated entry for zinc oxide ointment apply topically to buttocks four times a day for treatment/protection at 7:00am, 11:00am, 4:00pm, and 8:00pm.
-Zinc oxide ointment was documented as applied 109 times out of 124 opportunities from 01/01/20-01/31/20.

Review of Resident #2's February 2020 eMAR revealed:

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C 342	Continued From page 23 --There was a computer-generated entry for zinc oxide ointment apply topically to buttocks four times a day for treatment/protection at 7:00am, 11:00am, 4:00pm, and 8:00pm. -Zinc oxide ointment was documented as applied 111 times out of 116 opportunities from 02/01/20-02/29/20. Review of Resident #2's March 2020 eMAR revealed: --There was a computer-generated entry for zinc oxide ointment apply topically to buttocks four times a day for treatment/protection at 7:00am, 11:00am, 4:00pm, and 8:00pm. -Zinc oxide ointment was documented as applied four times daily from 03/01/20-03/05/20. -Zinc oxide ointment was documented as applied four times daily from 03/07/20-03/10/20. -There was no documentation zinc oxide was applied on 03/06/20 at 4:00pm. -Zinc oxide ointment was documented as applied on 03/11/20 at 7:00am and 11:00am. Observation of the medications on hand on 03/11/20 at 11:43am revealed there was no zinc oxide available for application. Observation of the MA on 03/11/20 at 11:43am revealed: -She went to Resident #2's room to look for zinc oxide but did not find any. -She asked Resident #2 if his "creams" were in his room and he replied "no, they packed it up" with his former roommate's items when he had moved out. Interview with Resident #2 on 03/11/20 at 12:10pm revealed the MA did not apply zinc oxide to his buttocks at 7:00am or 11:00am on	C 342		

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C 342	Continued From page 24 03/11/20. Interview with the MA on 03/11/20 at 1:50pm revealed: -She had applied zinc oxide stored in a medicine cup to Resident #2 on 03/11/20 at 7:00am. -She did not apply zinc oxide to Resident #2 at 11:00am. -She "clicked" all the medications and documented zinc oxide as administered by accident and needed to remove the 11:00am entry on 03/11/20 from the eMAR system. -The process for administering medications to residents was to administer the medication and then sign the eMAR. -The eMAR would "trigger" the medications due and she would sign all medications. -If she did not administer a medication, she would go back into the eMAR system and remove her signature but sometimes she "forgets, like today" and leaves the medication documented as administered. Interview with the Co-Administrator on 03/11/20 at 2:23pm revealed: -The facility had Medication Administration Policies and Procedures and she expected staff to follow them when administering medication. -The MA was supposed to administer the medications to the residents and then document on the eMAR the medications that were administered. -She did not know why the MA had signed on the eMAR that zinc oxide was applied to Resident #2 when the medication was not available.	C 342		

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2. Review of Resident #1's current FL2 dated 10/10/19 revealed:
-Diagnoses included major depressive disorder with psychosis, hypertension, hypokalemia, hyperlipidemia, gout, renal disorder and a history of an abdominal hernia.
-Resident #1 was semi-ambulatory.

Review of the Physician's orders for Resident #1 revealed:

-An order was written on 11/21/20 for TED hose to be applied daily for lower extermity edema.
-There were no orders to discontinue the TED hose for Resident #1.

Observation on 03/10/20 at 10:30am and again at 12:00pm revealed Resident #1 was not wearing TED hose.

Observation on 03/11/20 at 9:00am revealed Resident #1 was not wearing TED hose.

Review of Resident #1's January 2020 eMAR revealed:
-There was a computer-generated entry for applying knee hi TED hose in the morning at 8:00am and remove them in the evening at 8:00pm.
-TED hose were documented as applied 31 times from 01/01/20-01/31/20.

Review of Resident #1's February 2020 eMAR revealed:
-There was a computer-generated entry for

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applying knee hi TED hose in the morning at 8:00am and remove them in the evening at 8:00pm.
-TED hose were documented as applied 18 times from 02/01/20-0/29/20.
-There was no documentation of Resident #1's TED hose being applied on 02/14 and 02/16 but there was documentation the TED hose were removed at 8pm by staff on 02/14 and 02/16.

Review of the electronic Medication record administration notes for February 2020 revealed:
-There was documentation Resident #1 had refused her TED hose on 02/11 at 8am, 02/12 at 8pm, 02/13 at 8pm, 02/17 at 8pm, 02/21 at 8am, 02/21 at 8pm, 02/22 at 8am, 02/22 at 8pm, 2/23 at 8pm, 02/25 at 8am and 02/26 at 8am.

Review of Resident #1's March 2020 eMAR revealed:
-There was a computer-generated entry for applying knee hi TED hose in the morning at 8:00am and remove them in the evening at 8:00pm.
-TED hose was documented as applied 9 times from 3/1-3/11 at 8am.
-TED hose were documented as refused on 03/05 and 03/06 at 8am.
-TED hose were documented as removed on 03/05 and 03/06 at 8pm.

Interview with Resident #1 on 03/10/20 at 12:00pm revealed:
-She had TED hose available for her to wear.
-She was supposed to be wearing her TED hose daily because of the swelling in her legs.
-She had not been wearing her TED hose because staff was applying cream to a rash on her legs.
-She did not remember refusing to wear her TED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL043034	A. BUILDING: _____ B. WING _____	03/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE FAMILY CARE HOME	431 JUNNY ROAD ANGIER, NC 27501

(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 342	Continued From page 27 hose. Interview with a medication aide (MA) on 03/10/20 at 3:30pm revealed: -Resident #1 did have TED hose she was supposed to wear for the swelling of her legs. -She had not assisted Resident #1 in applying her TED hose on 03/10/20 as she expected the resident to put them on if she wanted to wear them. -She had initialed on the eMAR incorrectly that resident she had applied Resident #1's TED hose on 3/1, 3/2, 3/3 and 3/10. -She had not seen Resident #1 with her TED hose on in 2-3 weeks. Interview with a second MA on 03/11/20 at 11:20am revealed: -Third shift was responsible for applying TED hose for Resident #1. -She confirmed her initials on the eMAR dated 03/11/20 at 8:00am. -"I go down there clicking sometimes," in reference to the eMAR. -She did not recall applying the TED hose for Resident #1. Interview with the Co-Administrator on 03/10/20 at 2:00pm revealed: -She expected the MA's to apply TED hose for residents who had orders. -"We have to assist." -She expected staff to be documenting accurately on the eMAR.	C 342		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home	C935		

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C935	Continued From page 28 Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	C935		

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C935	Continued From page 29	C935		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff B) completed the 10, or 15 hour state approved medication aide training and completed the medication aide exam within 60 days.

The findings are:

Review of Staff B's Medication Aide (MA) personnel record revealed:
-Staff B was hired 01/22/20 as a MA.
-There was no documentation of MA employment verification in the past 24 months.
-There was no documentation Staff B had completed 5 hours of MA training.
-There was no documentation Staff B had completed a 10 hour or 15 hour MA training.
-There was documentation Staff B had completed the medication clinical skill checklist on 01/28/20.
-There was documentation Staff B had completed the MA exam on 03/29/16.

Review of three residents' electronic Medication Administration Record (eMAR) for February 2020 revealed Staff B documented the administration of medications on 02/5/20, 02/26/20, 02/27/20 and 02/28/20.

Review of three residents' eMAR for March 2020 revealed Staff B documented the administration of medications on 03/03/20, 03/06/20, 03/07/20 and 03/11/20.

Interview with Staff B on 03/11/20 at 1:23pm

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C935	Continued From page 30 revealed: -She had not had any medication training since she began her employment at the facility. -She had taken medication training about three years ago with another employer. Interview with the Licensed Health Professional Support (LHPS) nurse on 02/18/20 at 11:40am revealed: -She was last in the facility on 01/28/20 to conduct needed training for staff. -She had not been notified of any training needs since she was in the facility on 01/28/20. Interview with the Co-Administrator on 03/11/20 at 1:55pm revealed: -She was responsible for notifying staff of the training they were required to complete. -She was responsible for ensuring all staff had needed training. -She was responsible for notifying the pharmacy of the facility's training needs for new employees. -Staff B was a full time second shift MA and administered medications to the residents. -She thought Staff B had had the medication training but could not find it.	C935		