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 _____	09/04/2020

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 conducted a COVID-19 focused Infection Control survey with an onsite visit on 08/25/20 and a desk review survey on 08/25/20 to 08/28/20 and 08/31/20 to 09/04/20 with a telephone exit on 09/04/20.	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 ensure referral and follow up for 1 of 3 sampled residents (#3) with an appointment with a gastroenterologist that was missed and not rescheduled. The findings are: Review of Resident #3's hospital generated FL-2 and discharge summary dated 07/15/20 revealed: -Diagnoses included dysphagia, schizophrenia and diabetes mellitus type 2. -There was an order for a referral appointment with a gastroenterologist for dysphagia, gastroesophageal reflux disease (GERD), esophageal dilation (a procedure to expand the diameter of the esophagus), slow esophageal transit (food remaining in the esophagus for longer periods of time) and questionable esophageal web (rings or folds that block the esophagus partially or completely causing difficulty swallowing). -The resident needed a follow up appointment	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 246	Continued From page 1 with a gastroenterologist. Review of a discharge summary for Resident #3 from a local hospital dated 07/15/20 revealed: -The resident was admitted on 07/02/20 and discharged to the facility on 07/15/20. -The resident needed a follow up appointment with a gastroenterologist. Telephone interview with the Administrator on 09/02/20 at 11:59am revealed: -She contacted Resident #3's family member to obtain additional history prior to admission. -Resident #3's family member informed her that there was a family history of difficulty swallowing. -She reviewed Resident #3's FL-2 prior to admission and at admission. -She had concerns about Resident #3's speech and drooling. Telephone interview with the nurse manager at the gastroenterologist's office on 09/04/20 at 9:30am revealed: -Resident #3 had a telehealth appointment scheduled on 07/17/20. -The gastroenterologist was unable to reach Resident #3 by telephone for the telehealth appointment on 07/17/20 because there was no answer when they called the facility. -The gastroenterologist staff attempted to contact the facility to reschedule Resident #3's appointment on 07/17/20 and 07/21/20 but were not able to speak with anyone because there was no answer when they called the facility. -A staff person from the facility called the gastroenterologist on 09/03/20 to reschedule Resident #3's appointment to 09/15/20. -The nurse case manager was unable to identify which staff member from the facility called to reschedule Resident #3's appointment.	C 246		

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C 246	Continued From page 2 Telephone interview with the Administrator on 09/03/20 at 5:43pm revealed that she contacted the gastroenterologist to reschedule Resident #3's appointment to 09/15/20. Review of Resident #3's primary care provider (PCP) consultation notes revealed: -Resident #3 was seen by the facility PCP on 08/05/20 and 08/13/20. -There was no documentation or reference of Resident #3's need for gastroenterologist appointment. Telephone interview with Resident #3's PCP on 09/01/20 at 1:23pm revealed: -She first saw Resident #3 on 08/05/20. -Dysphagia was part of her assessment on her initial visit. -Facility staff reported to her on 08/05/20 that Resident #3 was having difficulties swallowing her medications. Telephone interview with hospital physician for Resident #3's on 09/04/20 at 2:38pm revealed: -He listed on the FL-2 that Resident #3 needed an appointment with a gastroenterologist due to her history of GERD, esophageal dilation, slow esophageal transit and questionable esophageal web. -He had concerns about her ability to swallow regular foods and did not want her to aspirate. -He was concerned about the delay in Resident #3 gastroenterologist appointment due to her risk of aspirating. -Her difficulties with swallowing could have caused hypoxia if food was suddenly caught in her throat, which would have caused her to stop breathing, aspiration pneumonia, which could lead to a coma and death.	C 246		

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	FCL043034	A. BUILDING: _____ B. WING _____	09/04/2020

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C 246	Continued From page 3 Telephone interview with the Resident Care Coordinator (RCC) on 09/03/20 at 4:03pm revealed: -She had received two FL-2's for Resident #3; the first was not signed (07/13/20) and the second was signed (07/15/20). -She thought the second FL-2 was the same as the first FL-2, she did not know the FL-2's were different until 09/03/20. -She "normally" followed the orders written on the discharge summary and not the FL-2. -On 08/01/20, she noticed the referral for the gastroenterologist. -Resident #3 had a telehealth appointment scheduled with the gastroenterologist; she did not know when the appointment was. Telephone interview with the Administrator on 09/04/20 at 11:54am revealed: -The RCC informed her on 09/03/20 she had not reviewed Resident #3's most current FL-2, which contained documentation the resident needed an appointment with a gastroenterologist. -The hospital sent an appointment card for Resident #3's gastroenterologist appointment scheduled for 07/17/20 at the facility. -The appointment scheduled on 07/17/20 should have been listed on the facility calendar for resident appointments. -Resident #3 was a "no show" for her telehealth gastroenterologist appointment on 07/17/20. -The delay in scheduling of Resident #3's gastroenterologist appointment "was an oversight." -She had been trying to follow up on referrals, but they had been busy due to a COVID-19 outbreak that began 07/22/20. -It was the RCC's responsibility to schedule appointments.	C 246		

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	FCL043034	A. BUILDING: _____ B. WING _____	09/04/2020

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C 246	Continued From page 4 -The appointment would have been made if it were not for the COVID-19 outbreak. Resident #3's care notes were requested from the facility on 08/27/20, 08/28/20, 09/02/20 and 09/03/20 and were not provided prior to survey exit. _____ The facility failed to ensure Resident #3 attended a telehealth appointment on 07/17/20 with a gastroenterologist and failed to reschedule the appointment. The resident had a diagnoses including dysphagia, gastroesophageal reflux disease (GERD), esophageal dilation (a procedure to expand the diameter of the esophagus), slow esophageal transit (food remaining in the esophagus for longer periods of time) and questionable esophageal web (rings or folds that block the esophagus partially or completely causing difficulty swallowing), placing the resident at risk of aspiration, aspiration pneumonia, coma or death. The facility's failure was detrimental to the health and safety of the resident and constitutes a Type B violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/04/20. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 19, 2020.	C 246		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional	C 284		

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 _____	09/04/2020

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

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C 284	Continued From page 5	C 284		

supplements and thickened liquids, shall be served as ordered by the resident's physician.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, telephone interviews and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 1 resident sampled (#3) who had a diagnosis of dysphagia and an order for chopped/mechanical soft diet.

The findings are:

Review of Resident #3's hospital generated FL-2 dated 07/15/20 revealed:
-Diagnoses included dysphagia, schizophrenia and diabetes mellitus type 2.
-The resident had a diet order for chopped solids.

Review of Resident #3's Resident Register dated 07/18/20 revealed the resident was on a regular diet.

Review of Resident #3's subsequent diet order from her primary care physician (PCP) dated 08/05/20 revealed her diet was changed to chopped/mechanical soft.

Telephone interview with Resident #3's PCP on 09/01/20 at 1:23pm revealed:
-She first saw Resident #3 on 08/05/20.
-Dysphagia was part of her assessment on her initial visit.
-Facility staff reported to her on 08/05/20 that Resident #3 was having difficulties swallowing her medications.
-Resident #3 had a diagnosis of dysphagia and a

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 _____	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 284	Continued From page 6	C 284		

special diet would have been needed to help improve her ability to swallow without coughing.
-She changed Resident #3's diet order to chopped/mechanical soft on 08/05/20.

Telephone interview with a medication aide (MA) on 08/31/20 at 2:13pm revealed:
-Resident #3 coughed when she ate.
-Resident #3 was on a regular diet.
-The Administrator was in the process of obtaining a diet order to change Resident #3's diet from regular to chopped.

Telephone interview with a personal care aide (PCA) on 09/01/20 at 12:56pm revealed:
-Resident #3 was on a regular diet.
-Resident #3 was served a chicken patty, stuffing, brussels sprouts and banana pudding for lunch on 09/01/20.
-Resident #3 did not require supervision with her meals and did not require assistance with cutting up her food.
-The cook prepared the meals, plated the meals for each resident and prepared their drinks.

Telephone interview with the cook on 09/01/20 at 1:04pm revealed:
-She prepared all meals, plated food for each resident and prepared their drinks.
-Resident #3 was on a regular diet.
-Resident #3 and all residents in her unit received the same diet, a regular diet.
-The Administrator or the RCC would notify her of each resident's diet order when there was an admission, or a resident was discharged back to the facility from the hospital.

Telephone interview with a second MA on 09/02/20 at 2:20pm revealed:
-Resident #3 coughed frequently when she ate.

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 _____	09/04/2020

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C 284	Continued From page 7 -Resident #3 was on a regular diet. -All residents in Resident #3's building was on a regular diet. Telephone interview with the Resident Care Coordinator (RCC) on 09/03/20 at 4:03pm revealed resident #3 had "some" difficulty with swallowing. Telephone interview with the Administrator on 09/03/20 at 11:24am revealed: -Resident #3 was on a chopped/mechanical soft diet. -Resident #3's PCP wrote a diet order on 08/05/20 for a chopped/mechanical soft diet. -She or the RCC informed the cook of a new resident's diet. -Diet orders were posted in the kitchen where the cook prepared meals. -The cook, MAs and PCAs should have known that Resident #3 was on a chopped/mechanical soft diet. Telephone interview with the cook on 09/04/20 at 11:00am revealed: -When there was a new admission, she received a form from the Administrator or RCC with the diet order. -The Administrator or RCC provided her with an updated diet list that she kept posted on the refrigerators in all buildings when there was a new admission, or a resident was discharged from the hospital. -Resident #3 had been on a regular diet and would "barely eat." -Resident #3 could not eat the food because it was solid. -On 09/01/20 she was informed by the Administrator or RCC that Resident #3 was on a pureed diet.	C 284		

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	FCL043034	A. BUILDING: _____ B. WING _____	09/04/2020

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

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C 284	Continued From page 8 -She prepared her food now in a blender using the pureed mode so that the texture was consistent with baby food. Telephone interview with the Administrator on 09/04/20 at 12:45pm revealed: -The cook was incorrect about Resident #3 being on a pureed diet. -She met with the cook earlier to review Resident #3's diet order of chopped/mechanical soft. -She also reviewed the diet list for residents with the cook to ensure her understanding of therapeutic diets. Telephone interview with Resident #3's hospital discharge physician on 09/04/20 at 2:38pm revealed: -Resident #3 required a special diet due to her difficulties with swallowing. -He had concerns about her ability to swallow regular foods and did not want her to aspirate. -If she received an inappropriate diet with her swallowing difficulties she could aspirate, which could lead to aspiration pneumonia. Resident #3's care notes were requested from the facility on 08/27/20, 08/28/20, 09/02/20 and 09/03/20 and were not provided prior to survey exit. _____ The facility's failed to serve a chopped mechanical soft diet to Resident #3 as ordered. Resident #3 had a diagnosis of dysphagia. The facility's failure resulted in the resident coughing when she ate her meals and resulted in the resident being at increased risk of aspiration pneumonia which was detrimental to the health and safety of the resident and constitutes a Type B Violation _____	C 284		

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	FCL043034	A. BUILDING: _____ B. WING _____	09/04/2020

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(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 284	Continued From page 9 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/20 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 19, 2020.	C 284		
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 interviews and record reviews, the facility failed to assure anti-anxiety medications were administered as ordered for 2 of 3 sampled residents (#1 and #3). 1. Review of Resident #1's current FL-2 dated 10/19/19 revealed diagnoses included major depressive disorder with psychosis, hypertension, hypokalemia, hyperlipidemia, gout, renal disorder and abdominal hernia. Review of unsigned Physician's Orders dated 11/18/19 for Resident #1 revealed alprazolam 0.25mg every 12 hours as needed (PRN) for anxiety; "hold for sedation" was listed with an original order date of 11/14/19.	C 330		

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	FCL043034	A. BUILDING: _____ B. WING _____	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 330	Continued From page 10 Review of a subsequent order dated 08/11/20 for Resident #1 revealed there were orders for alprazolam 0.5mg twice daily and to discontinue previous PRN order. Review of Resident #1's June 2020 electronic medication administration record (eMAR) revealed: -There was an entry for alprazolam 0.25mg twice daily PRN for anxiety; hold for sedation. -There was documentation the alprazolam order was written 02/06/20. -There was no documentation of the exact time frame between doses or the maximum 24 hour dosage. -There were 22 doses of alprazolam 0.25mg documented as administered between 06/01/20 and 06/30/20. -Of the 22 doses administered, 3 were documented for pain, 7 were documented for headache and 12 were documented for anxiety. Review of Resident #1's July 2020 eMAR revealed: -There was an entry for alprazolam 0.25mg twice daily PRN for anxiety; hold for sedation. -There was documentation the alprazolam order was written 07/14/20 and discontinued 08/11/20. -There was no documentation of the exact time frame between doses or the maximum 24 hour dosage. -There were 10 doses of alprazolam 0.25mg documented as administered between 07/01/20 and 07/13/20. -Of the 10 doses administered, 1 was documented for pain, 1 was documented for headache, 2 were documented for agitation and 6 were documented for anxiety. -There was an entry for alprazolam 0.5mg twice	C 330		

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	FCL043034	A. BUILDING: _____ B. WING _____	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 330	Continued From page 11 daily PRN for anxiety. -There was documentation the alprazolam order was written 07/14/20. -There was no documentation of the exact time frame between doses or the maximum 24 hour dosage. -There were 14 doses of alprazolam 0.5mg documented as administered between 07/14/20 and 07/31/20. -Of the 14 doses documented as administered, 1 was documented for pain, 3 were documented for headache, 1 was documented for agitation and 9 were documented for anxiety. Review of Resident #1's August 2020 eMAR revealed: -There was an entry for alprazolam 0.5mg twice daily PRN for anxiety. -There was documentation the alprazolam order was written 07/14/20 and discontinued 08/11/20. -There was no documentation of the exact time frame between doses or the maximum 24 hour dosage. -There were 8 doses of alprazolam 0.25mg documented as administered between 08/01/20 and 08/16/20. -Of the 10 doses administered, 1 was documented for pain, 1 was documented for headache and 6 were documented for anxiety. Telephone interview with Resident #1 on 09/02/20 at 3:49pm revealed: -She took alprazolam for anxiety and nerves. -She often felt anxious and nervous when her blood pressure was high. -She sometimes took alprazolam with acetaminophen which would help her sleep. -She took the acetaminophen for pain; she usually had a headache or pain in her legs.	C 330		

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 _____	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 330	Continued From page 12	C 330		

Telephone interview with a medication aide (MA) on 09/04/20 at 2:23pm revealed:
-Resident #1 usually asked for alprazolam for anxiety and acetaminophen for pain.
-She gave Resident #1 alprazolam for anxiety and acetaminophen for pain and documented administration on the eMAR and/or charting notes.
-If she entered pain for reason for administering alprazolam to Resident #1 on 08/10/20, it was a documentation error.

Telephone interview with a second MA on 09/02/20 at 2:19pm revealed:
-Alprazolam was for anxiety or agitation; she did not know who put on the eMAR the alprazolam was given for headaches or pain.
-She documented administering alprazolam for agitation on 07/07/20, 07/09/20 and 07/14/20.
-When Resident #1 asked for the alprazolam, the MAs would put in whatever the resident said; so if Resident #1 said it was a headache, that was what the MAs documented.

Review of Resident #1's June, July and August 2020 eMARs revealed there was no entry or documentation for acetaminophen administration.

Telephone interview with Resident #1's primary care provider (PCP) on 09/01/20 at 1:25pm revealed alprazolam was ordered for Resident #1 to treat anxiety and should only be given for anxiety.

Telephone interview with the Resident Care Coordinator (RCC) on 09/03/20 at 4:03pm revealed:
-She administered alprazolam to Resident #1 when the resident asked for it.
-Resident #1 frequently reported headaches, pain

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 _____	09/04/2020

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 330	Continued From page 13	C 330		

and anxiety related to high blood pressure.
-She explained to Resident #1 that alprazolam was not for a headache.
-Sometimes Resident #1 would ask for acetaminophen for a headache and then ask for alprazolam.
-All medication aides (MAs) knew not to administer alprazolam to Resident #1 for headaches or pain; the MAs knew alprazolam was for anxiety.
-She was responsible for reviewing eMAR orders and documentation, but she did not have the opportunity to reviews eMARs "recently".
-MAs may have just documented whatever Resident #1 told them when alprazolam was administered.

Telephone interview with the Administrator on 09/04/20 at 11:27am revealed:
-Resident #1 would see other residents getting their blood pressure consistently so she wanted her blood pressure checked consistently.
-MAs administered alprazolam when Resident #1 asked for it.
-The MAs made a mistake in documenting the reason for alprazolam administration on the eMAR for Resident #1.
-There were limited pre-typed choices on the computer system to choose from to document the reason a PRN medication was administered.
-MAs were able to type in reason not listed in the choices.
-Alprazolam was prescribed for anxiety.
-She and/or the RCC had reported Resident #1's frequent headaches and anxiety to the resident's PCP.
-She did routinely look at eMARs and documentation reasons for PRN medication administration but had not reviewed the eMARs for "a couple months".

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 _____	09/04/2020

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 330	Continued From page 14 Attempted interview on 09/03/20 at 10:17am with the MA who documented administering alprazolam to Resident #1 for pain on 07/11/20 was unsuccessful. Attempted interview on 09/03/20 at 10:22am with the MA who documented administering alprazolam to Resident #1 for headaches on 13 occasions between 06/02/20 and 08/02/20 was unsuccessful. 2. Review of Resident #3's hospital FL-2 dated 07/15/20 revealed: -Diagnoses included dysphagia, schizophrenia and diabetes mellitus type 2. -Medications listed to continue upon admission to facility included Clonazepam 0.5mg twice a day as needed (PRN) for anxiety. Review of Resident #3's physician orders dated 07/15/20 revealed clonazepam 0.5mg twice a day as needed (PRN) for anxiety. Review of Resident #3's July 2020 electronic medication administration record (eMAR) revealed: -There was an entry for clonazepam 0.5mg twice daily PRN for anxiety. -There were 12 doses of clonazepam 0.5mg documented as administered between 07/17/20 and 07/31/20. -Of the 12 doses administered, 1 was documented for pain and 11 were documented for anxiety. Review of Resident #3's August 2020 eMAR revealed: -There was documentation of a new order written	C 330		

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 _____	09/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 330	Continued From page 15 08/13/20 for clonazepam 0.5mg. to take 0.25mg every 12 hours as needed for anxiety/agitation. -There were 5 doses of clonazepam 0.25mg administered between 08/13/20-08/17/20. -Of the 5 doses administered, 1 was for headache and 4 were for anxiety. -On 08/17/20 there was a new order written to take clonazepam 0.5mg twice a day PRN for anxiety. -There were 11 doses of clonazepam 0.5mg administered between 08/17/20-08/27/20. -Of the 11 doses administered, 2 were for headache and 9 were for anxiety. Telephone interview with a medication aide (MA) on 09/02/20 at 2:23pm revealed if an order was not clear she resent that order back to the pharmacy for clarification. Attempted interview on 09/03/20 at 10:22am with the MA who documented administering clonazepam to Resident #3 for headaches on 3 occasions between 08/13/20 and 08/20/20 was unsuccessful. Telephone interview with the Administrator on 09/04/20 at 11:27am revealed: -She would have seen if a MA typed that they administered clonazepam for a headache instead of anxiety. -She looked at the eMAR dashboard weekly to check for any missed medications or problems. -She did not notice that clonazepam had been administered for headaches instead of anxiety. -She did review the eMAR, however during the past month she had been more concerned with monitoring her control logs. Attempted telephone interview with Resident #3's PCP on 09/04/20 at 10:28am was unsuccessful.	C 330		

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 _____	09/04/2020

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

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C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to health care and nutrition and food service. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up for 1 of 3 sampled residents (#3) with an appointment with a gastroenterologist that was missed and not rescheduled [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type B Violation)]. 2. Based on observations, telephone interviews and record reviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 1 resident sampled (#3) who had a diagnosis of dysphagia and an order for chopped/mechanical soft diet [Refer to Tag 284 10A NCAC 13G .0904(e)(4) Nutrition & Food Service (Type B Violation)].	C 912		