Division of Health Service Regulation

| 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 |
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| C 000 | Initial Comments<br><br>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<br><br>10A NCAC 13G .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>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.<br><br>The findings are:<br><br>Review of Resident #3's hospital generated FL-2 and discharge summary dated 07/15/20 revealed:<br>-Diagnoses included dysphagia, schizophrenia and diabetes mellitus type 2.<br>-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).<br>-The resident needed a follow up appointment | C 246 | "See Attachment" | 10/15/2020 |

RECEIVED
OCT 21 2020


LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Witten TITLE: CEO, Administrator, MSW (X6) DATE: 10/15/2020



Reviewed and accepted. 27 October 2020

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| C 246 | Continued From page 2<br><br>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.<br><br>Review of Resident #3's primary care provider (PCP) consultation notes revealed:<br>-Resident #3 was seen by the facility PCP on 08/05/20 and 08/13/20.<br>-There was no documentation or reference of Resident #3's need for gastroenterologist appointment.<br><br>Telephone interview with Resident #3's PCP on 09/01/20 at 1:23pm revealed:<br>-She first saw Resident #3 on 08/05/20.<br>-Dysphagia was part of her assessment on her initial visit.<br>-Facility staff reported to her on 08/05/20 that Resident #3 was having difficulties swallowing her medications.<br><br>Telephone interview with hospital physician for Resident #3's on 09/04/20 at 2:38pm revealed:<br>-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.<br>-He had concerns about her ability to swallow regular foods and did not want her to aspirate.<br>-He was concerned about the delay in Resident #3 gastroenterologist appointment due to her risk of aspirating.<br>-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 | "See Attachment" | 10/15/2020 |

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| C 246 | Continued From page 4<br>-The appointment would have been made if it were not for the COVID-19 outbreak.<br><br>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.<br><br>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.<br><br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 09/04/20.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 19, 2020. | C 246 | 11. See Attachment 4 | 10/15/2020 |
| C 284 | 10A NCAC 13G .0904(e)(4) Nutrition and Food Service<br><br>10A NCAC 13G .0904 Nutrition and Food Service<br>(e) Therapeutic Diets in Family Care Homes:<br>(4) All therapeutic diets, including nutritional | C 284 | | |

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| C 284 | Continued From page 6<br><br>special diet would have been needed to help improve her ability to swallow without coughing.<br>-She changed Resident #3's diet order to chopped/mechanical soft on 08/05/20.<br><br>Telephone interview with a medication aide (MA) on 08/31/20 at 2:13pm revealed:<br>-Resident #3 coughed when she ate.<br>-Resident #3 was on a regular diet.<br>-The Administrator was in the process of obtaining a diet order to change Resident #3's diet from regular to chopped.<br><br>Telephone interview with a personal care aide (PCA) on 09/01/20 at 12:56pm revealed:<br>-Resident #3 was on a regular diet.<br>-Resident #3 was served a chicken patty, stuffing, brussels sprouts and banana pudding for lunch on 09/01/20.<br>-Resident #3 did not require supervision with her meals and did not require assistance with cutting up her food.<br>-The cook prepared the meals, plated the meals for each resident and prepared their drinks.<br><br>Telephone interview with the cook on 09/01/20 at 1:04pm revealed:<br>-She prepared all meals, plated food for each resident and prepared their drinks.<br>-Resident #3 was on a regular diet.<br>-Resident #3 and all residents in her unit received the same diet, a regular diet.<br>-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.<br><br>Telephone interview with a second MA on 09/02/20 at 2:20pm revealed:<br>-Resident #3 coughed frequently when she ate. | C 284 | "See Attachment" | 10/15/2020 |

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| C 284 | Continued From page 8<br>-She prepared her food now in a blender using the pureed mode so that the texture was consistent with baby food.<br><br>Telephone interview with the Administrator on 09/04/20 at 12:45pm revealed:<br>-The cook was incorrect about Resident #3 being on a pureed diet.<br>-She met with the cook earlier to review Resident #3's diet order of chopped/mechanical soft.<br>-She also reviewed the diet list for residents with the cook to ensure her understanding of therapeutic diets.<br><br>Telephone interview with Resident #3's hospital discharge physician on 09/04/20 at 2:38pm revealed:<br>-Resident #3 required a special diet due to her difficulties with swallowing.<br>-He had concerns about her ability to swallow regular foods and did not want her to aspirate.<br>-If she received an inappropriate diet with her swallowing difficulties she could aspirate, which could lead to aspiration pneumonia.<br><br>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.<br><br>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 | "See Attachment" | 10/15/2020 |

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| C 330 | Continued From page 10<br><br>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.<br><br>Review of Resident #1's June 2020 electronic medication administration record (eMAR) revealed:<br>-There was an entry for alprazolam 0.25mg twice daily PRN for anxiety; hold for sedation.<br>-There was documentation the alprazolam order was written 02/06/20.<br>-There was no documentation of the exact time frame between doses or the maximum 24 hour dosage.<br>-There were 22 doses of alprazolam 0.25mg documented as administered between 06/01/20 and 06/30/20.<br>-Of the 22 doses administered, 3 were documented for pain, 7 were documented for headache and 12 were documented for anxiety.<br><br>Review of Resident #1's July 2020 eMAR revealed:<br>-There was an entry for alprazolam 0.25mg twice daily PRN for anxiety; hold for sedation.<br>-There was documentation the alprazolam order was written 07/14/20 and discontinued 08/11/20.<br>-There was no documentation of the exact time frame between doses or the maximum 24 hour dosage.<br>-There were 10 doses of alprazolam 0.25mg documented as administered between 07/01/20 and 07/13/20.<br>-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.<br>-There was an entry for alprazolam 0.5mg twice | C 330 | "See Attachment" | 10/15/2020 |

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| C 330 | Continued From page 12<br><br>Telephone interview with a medication aide (MA) on 09/04/20 at 2:23pm revealed:<br>-Resident #1 usually asked for alprazolam for anxiety and acetaminophen for pain.<br>-She gave Resident #1 alprazolam for anxiety and acetaminophen for pain and documented administration on the eMAR and/or charting notes.<br>-If she entered pain for reason for administering alprazolam to Resident #1 on 08/10/20, it was a documentation error.<br><br>Telephone interview with a second MA on 09/02/20 at 2:19pm revealed:<br>-Alprazolam was for anxiety or agitation; she did not know who put on the eMAR the alprazolam was given for headaches or pain.<br>-She documented administering alprazolam for agitation on 07/07/20, 07/09/20 and 07/14/20.<br>-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.<br><br>Review of Resident #1's June, July and August 2020 eMARs revealed there was no entry or documentation for acetaminophen administration.<br><br>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.<br><br>Telephone interview with the Resident Care Coordinator (RCC) on 09/03/20 at 4:03pm revealed:<br>-She administered alprazolam to Resident #1 when the resident asked for it.<br>-Resident #1 frequently reported headaches, pain | C 330 | "See Attachment" | 10/15/2020 |

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| C 330 | Continued From page 14<br><br>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.<br><br>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.<br><br>2. Review of Resident #3's hospital FL-2 dated 07/15/20 revealed:<br>-Diagnoses included dysphagia, schizophrenia and diabetes mellitus type 2.<br>-Medications listed to continue upon admission to facility included Clonazepam 0.5mg twice a day as needed (PRN) for anxiety.<br><br>Review of Resident #3's physician orders dated 07/15/20 revealed clonazepam 0.5mg twice a day as needed (PRN) for anxiety.<br><br>Review of Resident #3's July 2020 electronic medication administration record (eMAR) revealed:<br>-There was an entry for clonazepam 0.5mg twice daily PRN for anxiety.<br>-There were 12 doses of clonazepam 0.5mg documented as administered between 07/17/20 and 07/31/20.<br>-Of the 12 doses administered, 1 was documented for pain and 11 were documented for anxiety.<br><br>Review of Resident #3's August 2020 eMAR revealed:<br>-There was documentation of a new order written | C 330 | "See Attachment" | 10/15/2020 |

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| C 912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>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.<br><br>The findings are:<br><br>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)].<br><br>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 | "See Attachment" | 10/5/2020 |

# Absolute Care Assisted Living, LLC

COVID-19 Focused Infection Control Survey

Plan of Correction

10A NCAC 13G .0902(b) Health Care

In order to maintain compliance with state rule 10A NCAC 13G .0902(b) Health Care, the administrator will ensure that RCC/ Administrator shall schedule all referrals and follow up to meet the routine and acute health care needs of all residents. The Administrator/ RCC will review all new admissions and regularly scheduled appointment documentation upon admission and/ or return to facility. All follow-up and routine appointments will be schedule immediately and documented in our appointment scheduling book and calendar. The administrator will complete weekly reviews of appointment log and calendar for the next 30 days and then monthly thereafter to ensure that all appointments are scheduled, rescheduled and/or canceled will be rescheduled within 5 to 10 days of being requested by acute healthcare professionals. There will also be a Quality Improvement Audit of all resident charts to ensure compliance with resident health care needs. A plan of protection was completed immediately during survey and the follow up appointment was schedule for 09/15/20 was kept. The resident in question had surgery on 10/09/20 for esophageal dilation and it went well. Due to COVID -19 our agency had an outbreak from July 22nd through August 28th, 2020 which required a great deal of attention in order to prevent the spread and to containment of this Pandemic. This outbreak influenced my agencies ability to maintain all previous system proficiently. Thankful our agency was successful in containing COVID -19 and had no Fatalities.

10A NCAC 13G .0904(e)(4) Nutrition and Food Service

In order to maintain compliance with state rule 10A NCAC 13G .0904(e) (4) Nutrition and Food Service, the administrator will ensure that Therapeutic Diets in Family Care Homes, all therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the residents physician. The administrator / RCC audited all resident charts and made copies of all diet orders and created a book to include each diet order and compiled a Diet Order Sheet which will be displayed on the Refrigerator for all staff to see an ensure that residents are receiving appropriate diets at meal times. The Cook staff will receive training on how to prepare all diet meals for all residents. In addition, the administrator/ RCC will monitor weekly for the next 30 days meal preparation and services to ensure that the residents are being served the appropriate diet. Then monthly after that the Administrator/ RCC will monitor the meals and documentation to ensure everything is current and updated as needed. Upon any new admissions the diet order will be included in the dietary book and on the diet log within 24 hours of arrival to facility. There will also be Quarterly reviews of all resident Diets by Quality Improvement Team. Due to COVID -19 our agency had an outbreak from

July 22nd through August 28th, 2020 which required a great deal of attention in order to prevent the spread and to containment of this Pandemic. This outbreak influenced my agencies ability to maintain all previous system proficiently. Thankful our agency was successful in containing COVID -19 and had no Fatalities.

10A NCAC 13G .1004(a) Medication Administration

In order to maintain compliance with the state rule 10A NCAC 13G .01004(a) Medication Administration, the administrator will provide a Medication Aid meeting/ training to review the procedure and protocol for handling the documentation of residents medication and the use of the EMAR system. The administrator will also contact Express Care Pharmacy and request that the EMAR system be updated to include additional options for select for the needs of medication. The administrator/ RCC will begin completing weekly audits on EMAR to ensure that med techs are administering and documenting medication appropriately. The EMAR audits will then go to monthly thereafter and a Quarterly review by Quality Improvement Team will be conducting and documented. Due to COVID -19 our agency had an outbreak from July 22nd through August 28th, 2020 which required a great deal of attention in to prevent the spread and to containment of this Pandemic. This outbreak influenced my agencies ability to maintain all previous system proficiently. Thankful our agency was successful in containing COVID -19 and had no Fatalities.

G.S. 131 Declarations of Residents' Right

In order to maintain compliance with G.S. 131D-21(2) Declaration of Residents Rights, the Administrator/RCC will ensure that every resident shall have the following rights: To receive care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations. The Administrator will schedule a Residents Right training for all staff within the next 30 days and require all new employees to complete the training prior to hire. The administrator will conduct a survey of all Residents, Guardians, and Family members and Care Providers to ensure that they are receiving adequate and appropriate care and service. This survey will be completed Quarterly. The Quality Improvement Team will compile data to help agency make recommendations that may be necessary to improve the delivery of services and quality of care for all residents. Due to COVID -19 our agency had an outbreak from July 22nd through August 28th, 2020 which required a great deal of attention to prevent the spread and to containment of this Pandemic. This outbreak influenced my agencies ability to maintain all previous system proficiently. Thankful our agency was successful in containing COVID -19 and had no Fatalities.