STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001153	A. BUILDING: _____ B. WING _____	R 06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZUR FAMILY CARE HOME	711 ASKEW STREET BURLINGTON, NC 27217

(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 conducted an annual and follow-up survey on 06/30/21.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #2) related to a medication used to treat depression and an anti-fungal shampoo. The findings are: Review of Resident #2's current FL-2 dated 08/09/20 revealed diagnoses included unspecified neurocognitive disorder, unspecified depressive disorder, and eczema. a. Review of Resident #2's physician's visit summary dated 12/11/20 revealed: -There was an order for sertraline 50mg (used to treat depression) one tablet daily. -The visit summary was electronically signed by the primary care provider (PCP).	C 330		

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C 330	Continued From page 1 Review of Resident #2's April, May, and June 2021 Medication Administration Record (MAR) revealed: -There was no entry for sertraline 50mg one tablet daily. -Sertraline 50mg was not documented as administered from 04/01/21-06/30/21. Observation of Resident #2's medications on hand on 06/30/21 at 12:25pm revealed there was no sertraline 50mg available for administration. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/30/21 at 1:22pm revealed: -The pharmacy did not have an order sertraline 50mg to administered daily. -The pharmacy had not dispensed sertraline 50mg to Resident #2. -The facility was responsible for faxing all orders to the pharmacy to be processed and entered onto the MAR. Interview with Resident #2 on 06/30/21 at 3:07pm revealed: -He received his medications daily. -He did not know the name of all his medications. -He was not sure if he was ordered medications to treat depression. -At times he felt depressed, however he participated in activities and tried to stay busy. Interview with the Administrator on 06/30/21 at 1:45pm revealed: -He was responsible for administering medications to residents. -He was responsible for making sure all orders were faxed to the pharmacy to be put on the MAR. -He did not remember seeing an order for	C 330		

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C 330	Continued From page 2	C 330		

sertraline 50mg on the physician visit summary dated 12/11/20.
-He was responsible for reviewing the orders and making sure they were faxed to the facility.
-He was not sure why the sertraline 50mg order was not faxed to the pharmacy.

Attempted telephone interview with Resident #2's PCP on 06/30/21 at 1:05pm was unsuccessful.

b. Review of Resident #2's FL-2 dated 08/09/20 revealed there was an order for ketoconazole shampoo 2% wash scalp and face three times per week.

Revew of Resident #2's April 2021 Medication Administration Record (MAR) revealed:
-There was an entry for ketoconazole shampoo 2% (used to treat scalp fungal infections) wash scalp and face once daily on Monday, Wednesday, and Friday at 8:00am.
-Ketoconazole shampoo 2% was documented as administered 13 out of 13 opportunities.

Review of Resident #2's May and June 2021 MAR revealed:
-There was no entry for ketoconazole shampoo 2% three times per week.
-Ketoconazole shampoo was not documented as given from 05/01/21-06/30/21.

Observation of Resident #2's medications on hand on 06/30/21 at 12:25pm revealed there was no ketoconazole shampoo 2% available for administration.

Telephone interview with the pharmacy technician from the facility's contracted pharmacy on 06/30/21 at 1:22pm revealed:
-The pharmacy did not have a current order for

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C 330	Continued From page 3	C 330		

ketoconazole shampoo 2% three times per week.
-A 7oz. bottle of ketoconazole shampoo 2% was last filled on 09/20/18.
-The last order received for ketoconazole shampoo was in 2018.
-The pharmacy did not have a current order for ketoconazole shampoo to refill the medication.
-The facility was responsible for faxing all orders to the pharmacy to be entered onto the MAR.

Interview with Resident #2 on 06/30/21 at 3:07pm revealed:
-He received medications daily.
-He had not received ketoconazole shampoo 2% "in a while".
-He did not know if the shampoo was at the facility.
-He did not have ketoconazole shampoo in his bathroom.
-At times, he had an itchy scalp, however he did not have severe itching or an infection on his scalp.

Interview with the Administrator on 06/30/21 at 1:45pm revealed:
-He was responsible for administering medications to residents.
-He was responsible for making sure all orders were faxed to the pharmacy to be put on the MAR.
-He did not know why the ketoconazole shampoo order fell off the MAR.
-Since the ketoconazole order fell off the MAR, it was not reordered or administered.
-He was responsible for calling the pharmacy and ensuring the medication as available for administration.
-He did not know what happened with the ketoconazole shampoo 2% order.

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C 330	Continued From page 4 Attempted telephone interview with Resident #2's PCP on 06/30/21 at 1:05pm was unsuccessful.	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 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 medication administration records were accurate for 1 of 3 sampled residents (Resident #2). The findings are:	C 342		

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C 342	Continued From page 5 Review of Resident #2's current FL-2 dated 08/09/20 revealed diagnoses included unspecified neurocognitive disorder, unspecified depressive disorder, and eczema. a. Review of Resident #2's physician's visit summary dated 12/11/20 revealed: -There was an order for sertraline 50mg (used to treat depression) one tablet daily. -The visit summary was electronically signed by the primary care provider (PCP). Review of Resident #2's April, May, and June 2021 Medication Administration Record (MAR) revealed: -There was no entry for sertraline 50mg one tablet daily. -Sertraline 50mg was not documented as given from 04/01/21-06/30/21. Observation of Resident #2's medications on hand on 06/30/21 at 12:25pm revealed there was no sertraline 50mg available for administration. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 06/30/21 at 1:22pm revealed: -The pharmacy did not have an order sertraline 50mg to administered daily. -The facility was responsible for faxing all orders to the pharmacy to be processed and entered onto the MAR. -MARs were sent to the facility at the end of each month for the following month. -The facility was responsible for reviewing the MAR for errors, making corrections and notifying the pharmacy. -The facility could handwrite orders if they did not appear on the MAR.	C 342		

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C 342	Continued From page 6 Interview with the Administrator on 06/30/21 at 1:45pm revealed: -He was responsible for making sure all orders were faxed to the pharmacy to be put on the MAR. -He did not remember seeing an order for sertraline 50mg on the physician visit summary dated 12/11/20. -He was responsible for reviewing the orders and making sure they were faxed to the pharmacy. -He was not sure why the sertraline 50mg order was not faxed to the pharmacy. -The facility was responsible for faxing all orders to the pharmacy to be processed and entered onto the MAR. -MARs were sent to the facility at the end of each month for the following month. -He was responsible for reviewing the MAR for errors, making corrections and notifying the pharmacy. -He could handwrite orders if they did not appear on the MAR. -The sertraline 50mg was overlooked. b. Review of Resident #2's FL-2 dated 08/09/20 revealed there was an order for ketoconazole shampoo 2% wash scalp and face three times per week. Review of Resident #2's April 2021 Medication Administration Record (MAR) revealed: -There was an entry for ketoconazole shampoo 2% (used to treat scalp fungal infections) wash scalp and face once daily on Monday, Wednesday, and Friday at 8:00am. -Ketoconazole shampoo 2% was documented as administered 13 out of 13 opportunities. Review of Resident #2's May and June 2021 MAR revealed:	C 342		

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C 342	Continued From page 7 -There was no entry for ketoconazole shampoo 2% three times per week. -Ketoconazole shampoo was not documented as given from 05/01/21-06/30/21. Observation of Resident #2's medications on hand on 06/30/21 at 12:25pm revealed there was no ketoconazole shampoo 2% available for administration. Telephone interview with the pharmacy technician from the facility's contracted pharmacy on 06/30/21 at 1:22pm revealed: -The pharmacy did not have a current order for ketoconazole shampoo 2% three times per week. -A 7oz. bottle of ketoconazole shampoo 2% was last filled on 09/20/18. -The last order received for ketoconazole shampoo was in 2018. -The pharmacy did not have a current order for ketoconazole shampoo to refill the medication. -The facility was responsible for faxing all orders to the pharmacy to be entered onto the MAR. Interview with the Administrator on 06/30/21 at 1:45pm revealed: -He was responsible for administering medications to residents. -He was responsible for making sure all orders were faxed to the pharmacy to be put on the MAR. -He did not know why the ketoconazole shampoo order fell off the MAR. -Since the ketoconazole order fell off the MAR, it was not reordered or administered. -He did not know what happened with the ketoconazole shampoo 2% order. -The facility was responsible for faxing all orders to the pharmacy to be processed and entered onto the MAR.	C 342		

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C 342	Continued From page 8 -MARs were sent to the facility at the end of each month for the following month. -The facility was responsible for reviewing the MAR for errors, making corrections and notifying the pharmacy. -The facility could handwrite orders if they did not appear on the MAR.	C 342		