STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl043037	A. BUILDING: _____ B. WING _____	08/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE FAMILY CARE II	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 an annual survey on Augusr 5, 2021.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews observations and interviews, the facility failed to ensure 1 of 3 sampled residents had an initial tuberculosis (TB) test upon admission (Resident #2) and 3 of 3 sampled residents had no second TB test since admission (Residents #1, #2, and #3). The findings are: 1. Review of Resident #1's current FL2 dated 07/07/21 revealed diagnoses included schizo-affective disorder, major depressive disorder and hypertension. Review of Resident #1's Resident Register revealed an admission date of 07/29/2020.	C 202		

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C 202	Continued From page 1 Review of Resident #1's record revealed: -There was documentation on 07/16/20, prior to admission, of a TB skin test being completed. -There was no documentation on the "TB immunization record" of a second TB skin test being completed. Attempted interview with Resident #1 was unsuccessful. Attempted telephone interview with the Resident Care Director (RCD) on 08/05/21 was unsuccessful. Refer to interview with the primary care physician (PCP) on 08/05/21 at 2:10pm. Refer to interview with the Administrator on 08/05/21 at 3:20pm. 2. Review of Resident #2's current FL2 dated 02/03/21 revealed diagnoses included Type II diabetes mellitus (DM), depression and hypertension. Review of Resident #2's Resident Register revealed an admission date of 12/01/20. Review of Resident #2's record revealed: -There was documentation on 09/18/17, prior to admission, of a TB skin test being completed. -There was no documentation on the "TB immunization record" of a second TB skin test being completed. Attempted interview with Resident #2 was unsuccessful. Attempted telephone interview with the RCD on 08/05/21 was unsuccessful.	C 202		

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C 202	Continued From page 2 Refer to interview with the PCP on 08/05/21 at 2:10pm. Refer to interview with the Administrator on 08/05/21 at 3:20pm. 3. Review of Resident #3's current FL2 dated revealed diagnoses included diabetes mellitus (DM) Type 2, paranoid schizophrenia and dementia. Review of Resident #3's Resident Register revealed an admission date of 11/25/20. Review of Resident #3's record revealed: -There was no documentation of a "TB immunization record" in Resident #3's record. -There was no documentation of a first or second TB skin test being completed. Attempted interview with Resident #3 was unsuccessful. Attempted telephone interview with the RCD on 08/05/21 was unsuccessful. Refer to interview with the PCP on 08/05/21 at 2:10pm. Refer to interview with the Administrator on 08/05/21 at 3:20pm. _____ Interview with the primary care physician (PCP) on 08/05/21 at 2:10pm revealed: -She did not administer the TB test to the residents upon admission or after admission. -She did not know who administered the TB test to her residents.	C 202		

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C 202	Continued From page 3 -She did not review resident records for TB compliance. Interview with Administrator on 08/05/21 at 3:20pm revealed: -The Resident Care Director (RCD) was responsible for ensuring the initial TB tests for the residents were administered prior to admission and a second TB test after admission. -She thought the registered nurse (RN) who assessed the residents with the Licensed Health Professional Support (LHPS) quarterly tasks also administered the TB tests. -The RCD was responsible for ensuring the documentation in the residents' records was complete and in compliance. -The RCD was not available at this time due to personal reasons.	C 202		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care	C 254		

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C 254	Continued From page 4 being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a registered nurse (RN) completed an on site Licensed Health Professional Support (LHPS) review and physical assessment evaluation on a quarterly basis for 2 of 3 residents (Residents #2 and #3) sampled with required LHPS tasks including ambulation using assistive devices (Residents #2 and #3) and thromboembolic (TED) hose to prevent blood clots (Resident #2). The findings are: 1. Review of Resident #2's current FL2 dated 02/03/21 revealed: -Diagnoses included Type II diabetes mellitus (DM), depression, arthritis and osteoporosis. -The resident was intermittently disoriented and ambulatory. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 11/07/16. Review of Resident #2's current assessment and care plan dated 02/03/21 revealed: -The resident required staff supervision with ambulation. -The resident had an order for thromboembolic hose to be applied in the morning and removed in the evening.	C 254		

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C 254	Continued From page 5 Review of Resident #2's LHPS review dated 03/23/21 revealed: -LHPS tasks documented by the RN included ambulation using assistive devices that required physical assistance. -The resident required a wheelchair for mobility. -There was no documentation for applying or removing TED hose. -The recommendation was for a follow up assessment in 90 days. Review of Resident #2's record revealed there were no LHPS reviews after 03/23/21 were completed for the resident. Observation of Resident #2 on 08/04/21 between 10:15am and 11:00am revealed: -The resident was seated in a wheelchair in the common room with the television on. -The resident had TED hose applied bilaterally. -The resident did not respond when attempted to engage in conversation. Interview with a personal care aide (PCA) on 08/05/21 at 10:30 pm revealed: -She applied Resident #2's TED hose in the morning. -She had been applying the TED hose for several months. -The resident was not able to ambulate independently in her wheelchair. -She was dependent on the staff to ambulate in her wheelchair. Attempted telephone interview with the Resident Care Director on 08/05/21 was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #2 was not	C 254		

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C 254	Continued From page 6 interviewable. Refer to telephone interview with the current LHPS nurse on 08/05/21 at 10:10am revealed: Refer to telephone interview with the previous LHPS nurse on 08/05/21 at 11:15am. Refer to telephone interview with the Administrator on 08/05/21 at 3:20pm. 2. Review of Resident #3's current FL2 dated 12/02/20 revealed: -Diagnoses included paranoid schizophrenia, Type II diabetes and vascular dementia. -The resident was intermittently disoriented. -She was documented as semi-ambulatory with a rollator. -Fingerstick blood sugar checks (FSBS) were ordered three times a week. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 11/25/20. Review of Resident #3's current assessment and care plan dated 12/02/20 revealed: -The resident required limited assistance with ambulation and supervision with transfers. -There was no documentation of an assistive device for ambulation or FSBS checks three times a week. Review of Resident #3's licensed health professional support (LHPS) review dated 03/23/21 revealed: -LHPS tasks documented by the RN included ambulation with an assistive device and FSBS checks three times a week. -The assistive device documented was a rollator.	C 254		

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C 254	Continued From page 7 -The recommendation was for a follow up assessment in 90 days. Review of Resident #3's record revealed no LHPS reviews after 03/23/21 were completed for the resident. Observation of Resident #3 on 08/05/21 at 2:00-2:30pm revealed: -Resident #3 was sitting in the common living room watching television. -She had a rollator beside her chair. -She was not conversational. Interview with a medication aide (MA)/PCA on 08/04/21 at 2:30pm revealed: -Resident #3 used a rollator when she ambulated. -She usually did not need reminders to use her rollator when ambulating. Attempted telephone interview with the Resident Care Director on 08/04/21 was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to telephone interview with the current LHPS nurse on 08/05/21 at 10:10am. Refer to telephone interview with the previous LHPS nurse on 08/05/21 at 11:15am. Refer to interview with the Administrator on 08/05/21 at 3:20pm. _____ Telephone interview with the current LHPS nurse on 08/05/21 at 10:10am revealed: -She had recently picked up this facility as the current Licensed Health professional Support	C 254		

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C 254	Continued From page 8	C 254		

(LHPS) registered nurse (RN), and was planning on visiting the facility in the next few weeks.
-At this time she relied on the Resident Care Director (RCD) to let her know when a resident had a new task or the residents who were due for their quarterly assessment.
-Eventually she would be creating a quarterly schedule of the residents who had tasks and needed a review for her records.
-She had contacted the RCD last week and was told there were no quarterly LHPS assessments due for the residents.

Telephone interview with the previous LHPS nurse on 08/05/21 at 11:15am revealed:
-She had completed the LHPS assessments on the residents on 03/23/21 for the facility.
-She was filling in as the LHPS RN until the position was filled.
-She informed the RCD that the agency of her employment should be contacted to schedule a time for her to complete assessments at the facility.
-She relied on the facility staff to inform her employer which residents needed a quarterly assessment update, and if there were any residents with new tasks.
-She would complete the LHPS assessment paperwork and place it in the resident's record or leave it on the RCD desk to be reviewed.
-She had not completed any LHPS quarterly reviews for the residents at the facility since 03/23/21.

Telephone interview with the Administrator on 08/05/21 at 3:20pm revealed:
-It was the responsibility of the RCD to track the LHPS assessments and schedule the RN to come to the facility to complete the assessments.
-The RCD was also responsible for tracking new

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C 254	Continued From page 9 LHPS tasks for the residents and including those residents in the schedule of the LHPS nurse. -She did not know there had not been an LHPS quarterly assessment on 3 of 3 residents sampled since 03/23/21. -It was her expectation the LHPS assessments for residents with tasks would be scheduled and completed quarterly by an RN.	C 254		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for staff guidance for 2 of 3 sampled residents (Residents #2 and #3), who had a physician's order for a low carbohydrate diabetic diet. The findings are: Review of Resident #2's current FL2 dated 02/03/21 revealed: -Diagnoses included Type II diabetes mellitus (DM), osteoporosis, anemia and hypertension. -There was a diet order for no concentrated sweets. Observation of the facility's diet menu in building #4's kitchen revealed:	C 270		

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C 270	Continued From page 10 -There was a 4 week Cycle 1, 2021 menu in a binder that listed three meals and snacks, Sunday though Saturday, for a regular diet with no added salt. -There were no therapeutic diet menus available to serve as guidance for the staff in the binder. -There was no low carbohydrate diabetic diet menu available for staff to reference. Observation of the lunch meal service on 08/05/21 in building #4 from 12:00pm to 12:35pm revealed: -There were no diet orders for the residents posted in the kitchen or located in the kitchen. -There were 6 residents at the lunch meal, including Resident #2. -All the residents were served turkey and noodle casserole, green beans, bread and pears in sweetened juice for dessert. -Beverages served were a 6 ounce glass of water and an eight ounce glass of sweetened lemonade. Without a therapeutic diet menu it could not be determined if Resident #2 was served the appropriate meal. Refer to interview with the cook on 08/04/21 at 2:50pm. Refer to a telephone interview with Resident #2's primary care provider (PCP) on 08/05/21 at 2:10pm. Refer to a telephone interview with the Administrator on 08/05/21 at 3:20pm. Based on observations, interviews and record reviews it was determined Resident #2 was not interviewable.	C 270		

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C 270	Continued From page 11 2. Review of Resident #3's current FL2 dated 12/02/20 revealed: -Diagnoses included paranoid schizophrenia, anemia and Type II diabetes mellitus (DM). -There was a diet order for a low carbohydrate diabetic diet. Observation of the lunch meal service on 08/05/21 in building #4 from 12:00pm to 12:35pm revealed: Resident #3 was served turkey and noodle casserole, green beans, bread and pear in sweetened juice for dessert. -Beverages served were a 6 ounce glass of water and an eight ounce glass of sweetened lemonade. Without a therapeutic diet menu it could not be determined if Resident #3 was served the appropriate meal. Refer to interview with the cook on 08/04/21 at 2:50pm. Refer to telephone interview with Resident #3's PCP on 08/05/21 at 2:10pm. Refer to telephone interview with the Administrator on 08/05/21 at 3:20pm. Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable. _____ Interview with the cook on 08/04/21 at 2:50pm. -She was responsible for preparing the breakfast and lunch meals for the residents. -She served the same meal to all the residents in the facility.	C 270		

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C 270	Continued From page 12 -She thought all the residents were on a regular diet. -She did not know two of the residents were on low carbohydrate diabetic diets. -There was no list posted in the kitchen with the resident's diet orders. -She did not know if there was any guidance for preparing meals for residents on a therapeutic diet. -She only served regular diets, chopped meats and pureed meals. -She had not been instructed to follow any other menu except the regular menu. Interview with the primary care physician (PCP) on 08/05/21 at 2:10pm revealed: -She did not know there was no menu guidance for residents on a therapeutic diet. -She did not supervise meals when she was visiting the residents. -Her expectation was residents should be served the appropriate meal for their physician ordered diets. Telephone interview with the Administrator on 08/04/21 at 3:52pm revealed: -She had contracted with their food distributor for a cycle of menus for regular, no salt and no concentrated sweets diets. -This 4 week cycle of menus were delivered to the facility every quarter. -She had been using this cycle of menus for several years. -There were diet orders for each resident in a red binder in the kitchen of each building. -The food was prepared in one building on the campus and delivered to each building in a warmer. -The kitchen where the food was prepared should have a regular menu and therapeutic menus	C 270		

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C 270	Continued From page 13 posted or available for the cook. -They should also have a list of the residents diets in each building. -It was the responsibility of the cooks to check the diet of each resident and prepare the correct menu items as directed on the therapeutic menu guidance. -There were 2 cooks in the facility and they have both been trained to review the diet orders for each resident before meals were prepared in case there has been a change in orders, and to follow the menu for that diet. -She was responsible for the training and supervision of the cooks and their preparation of meals. -She did not know the cook was serving all the residents from the regular diet menu.	C 270		