AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: FCL033062	A. BUILDING _____ B. WING _____	R 07/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
B J'S FAMILY CARE HOME	716 HUGO STREET DURHAM, NC 27704

received pg 1 on 09/19/21

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on July 23, 2021 and July 27, 2021, with a telephone exit on July 28, 2021.	C 000		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews the facility failed to provide supervision for 1 of 3 sampled residents (Resident #1) who eloped twice from the facility. The findings are: Review of Resident #1's current FL2 dated 06/11/21 revealed: -Diagnoses included schizophrenia. -He was constantly disoriented and ambulatory. -The resident had wandering behavior. Review of Resident #1's care plan dated 04/12/21 revealed: -There was documentation the resident was sometimes disoriented. -There was documentation the resident was forgetful. -Wandering behaviors were not checked off. -Mental health history was not completed.	C 243		

...sion of Health Service Regulation
...ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara Bright | TITLE: Administrator | (X6) DATE: 9/9/2021

...ATE FORM ... (X6) ... If continuation sheet 1 of 30

reviewed and acknowledged 9/19/21 Jo Scarlett

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 243	Continued From page 1 1. Review of Resident #1's incident report dated 11/22/20 revealed: -Resident #1 went out back to smoke a cigarette at 11:00am. -As he walked by, he stated he was going to the store. -As of 4:00 pm, the resident had not returned so police were notified, and a missing person report was filed. -A family member who was his guardian and the Administrator were notified. -The report did not say what time the resident was returned to the facility or where he was found. Based on observations and interviews there was no Sign-Out Register available for the date 11/22/20. Review of Resident #1's record revealed: -There were no progress notes or other information in the record regarding the incident on 11/22/20. -There was no documentation of interventions or increased supervision. Telephone interview with Resident #1's guardian on 07/28/21 at 9:00am revealed: -On 11/22/20, the facility had notified her of the resident going to the store and not returning. -Staff said the resident left around 11:00am and usually came straight back to the facility. -At 4:00 pm, he had not returned to the facility, so staff notified the police. -The resident showed up at her house at 9:45pm that night. -She lived 6.5 miles away from the facility. -She did not know if anything was put in place to prevent it from happening again. -Prior to 11/22/20, the resident had walked off	C 243		

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C 243	Continued From page 2 from the facility and went to the store. -She had given permission for the resident to walk to the store to help decrease the chance of him walking off because he liked to be out in the community with his friends. Interview with a Supervisor-in-Charge (SIC) on 07/27/21 at 11:30 revealed: -Resident #1 had walked away 3 or 4 times since being at the facility. -On 11/22/20, Resident #1 went out back to the smoking area to smoke. -She checked on him about 15 minutes later and Resident #1 was not out back at the smoking area. -She notified Resident #1's guardian, the Administrator, and made a missing person report at 4:00pm. -The police could not do anything because he had not been gone for 24 hours. -Resident #1 had walked away 3 or 4 times since being at the facility. -Resident #1 would just leave and not sign out to go to the store and visit his friends. -The coffee shop he liked to visit was about a mile away. -Staff always looked there first if anything happened. -The Administrator had notified the guardian in regards to the resident walking to the store and obtained permission for him to do so. -She tried to keep an eye on Resident #1 during his smoke break, but it was hard because those breaks were at mealtimes and she had to prepare the meal. -Staff had not done anything different to provide supervision for the resident. Interview with the Administrator on 07/27/21 at 3:00 pm revealed:	C 243		

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C 243	Continued From page 3 -Resident #1 did not have wandering behaviors. -On 11/22/20, Resident #1 verbally told the SIC he was going to the store. -The store was about 10 blocks away. -His guardian had given permission for him to go to the store. -Resident #1 did not return because he was hanging out with a family member. Telephone interview with a Representative from the Community Outreach Program and Mental Health Provider (MHP) on 07/28/21 at 10:52am revealed they were not made aware of Resident #1's elopement on 11/22/20. Attempted interview with Resident #1 on 07/27/21 at 9:45 am was unsuccessful. 2. Review of Resident #1's incident report dated 07/26/21 revealed: -At 6:40pm, the resident walked away from the facility to go use a phone. -He did not say anything. -The Administrator called and asked where Resident #1 was at. -The Administrator said she had received a call from an outreach community program stating that the resident had threatened to hurt another resident. -While the Administrator was talking with the outreach staff, Resident #1 was walking down the street. -The police were also coming down the street behind the resident. -The police spoke with the resident and he went voluntarily to the local emergency room for evaluation. -The guardian was notified, and they moved the resident into a different bedroom.	C 243		

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C 243	Continued From page 4 Review of the Sign-Out Register revealed no resident had signed out on 07/26/21. Review of Resident #1's record revealed: -There were no progress notes or other information in the record regarding the incident on 07/26/21. -There was no documentation of increased supervision. Telephone interview with Resident #1's guardian on 07/28/21 at 9:00am revealed: -On 07/26/21 at 12:40pm, the resident called her and told her that everyone was talking about him and he needed to get out of there, so she instructed him to call 911. -Several hours later at 6:40pm, she received a call from the facility stating that the resident went to the hospital for evaluation due to threatening another resident. -The resident usually had incidents, in which he would become upset, throughout the year when it was time for him to receive his check. -The resident did not understand that his check paid for his living at the facility. Interview with a Supervisor-in-Charge (SIC) on 07/27/21 at 11:30 revealed: -While trying to clean the kitchen, the Administrator called around 6:40 pm and asked where Resident #1 was. -She went to check the yard, but he was not there. -Two other staff drove down the road looking for Resident #1. -One of the staff located Resident #1 and tried to talk to him but he would not get in the car, so staff drove slowly beside the resident. -A police officer came up behind Resident #1 and the staff driving slowly.	C 243		

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C 243	Continued From page 5 -The police officer stopped and spoke with Resident #1 and he went voluntarily to the hospital for evaluation. -She notified the guardian -She did not know how long Resident #1 was gone. Interview with another SIC on 07/27/21 at 1:58pm revealed: -Resident #1 walked around the block daily. -On 07/26/21, he was working with the resident records at the kitchen table when Resident #1 came out of his bedroom and was mumbling, so he asked the resident if he was okay. -Resident #1 said he was okay and asked for a pen so he could sign out and go for a walk. -It appeared as though Resident #1 had signed out, but the SIC did not check the sign-out log. -At 4:20pm, Resident #1 returned from his walk and was still mumbling. -Resident #1 was gone about 15 minutes. -Resident #1 walked outside and smoked a cigarette and came back in. -He then received a phone call from the Administrator instructing him to go find the resident. -He was not sure how much time had past between the time Resident #1 came back inside and the time when the Administrator called. -Resident #1 was found on a dirt road one street over. -He asked Resident #1 what was wrong, and he said he was tired of the other residents' mess. -Resident #1 refused to get in the car so he drove slowly beside the resident. -Resident #1 repeated himself stating he was tired of the other residents and the manager was trying to kill him. -They returned to the house and stopped out front, three minutes later a police officer arrived.	C 243		

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C 243	Continued From page 6 -He went voluntarily with the police officer to the local emergency room. -Resident #1 had walked off right after he had smoked his cigarette. -Resident #1 had mumbled all day but he thought he was okay because he had laughed and joked with other residents throughout the day. -When a resident walked off, staff would go look for the resident in the area the resident frequented. -The police were familiar with Resident #1 because he had walked off before, last year sometime. -Staff were supposed to notify the Administrator, guardian, and the primary Care Provider (PCP) when a resident walked off. -There had been two staff at the facility this month to help monitor Resident #1. Interview with the Administrator on 07/27/21 at 3:00 pm revealed: -Resident #1 did not walk off on 07/26/21. -Resident #1 and his roommate had words. -The roommate reached for Resident #1 and he ran off. -Resident #1 called the Community Outreach Program from a neighbor's phone. -Resident #1 had thoughts of killing his roommate. -Resident #1 left in a hurry because the roommate reached for him. -The Community Outreach Program staff called 911 and the police met Resident #1 back at the facility. -Resident #1 was transported to the hospital for evaluation voluntarily. Telephone interview with Resident #1's PCP on 07/28/21 at 9:21am revealed: -The resident had only been with that PCP for	C 243		

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C 243	Continued From page 7 about 4 months. -The PCP was not made aware of the incident on 07/26/21. Telephone interview with a Representative from the Community Outreach Program and MHP on 07/28/21 at 10:52am revealed: -On the afternoon of 07/26/21, the Community Outreach crisis line received a phone call from Resident #1 stating he had thoughts of killing everyone in the home. -Resident #1 had walked down the street, not sure how far, and used the neighbor's phone to call the crisis line. -Resident #1 told them that everyone in the home talked about him and he did not get his breathing medication. -Resident #1 said he wanted to be his own guardian. -Crisis intervention immediately called the home twice but did not get an answer, so they called the homeowner. -They did not call 911 for the police to meet the resident back at the home. -They did not know who called the police. -They requested to set up a meeting with the staff and the guardian. Attempted interview with Resident #1 on 07/27/21 at 9:45 am was unsuccessful. _____ The facility failed to provide supervision for Resident #1 with a diagnosis of schizophrenia, which resulted in Resident #1 eloping from the facility twice. This failure resulted in substantial risk for physical harm and neglect to the resident which constitutes a Type B Violation. _____ The facility provided a plan of protection on 07/27/21 in accordance with G.S. 131D-34.	C 243		

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C 243	Continued From page 8 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 18, 2021.	C 243		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) including a medication used to prevent wheezing and shortness of breath and a medication used to lower triglycerides (Resident #1) and a medication used to treat rhinitis, pain, and a chemical dependence (Resident #3). The findings are: 1. Review of Resident #1's current FL2 dated 06/11/21 revealed diagnoses included schizophrenia. a. Review of Resident #1's current FL2 dated 06/11/21 revealed there was an order for	C 330		

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C 330	Continued From page 9 budesonide-formoterol (used for treatment of asthma) 80-4.5mg inhale 2 puffs 2 times daily. Review of Resident #1's medication administration record (MAR) for May 2021 revealed: -There was an entry for budesonide-formoterol 80-4.5mg inhale 2 puffs 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm 05/01/21 to 05/31/21. Review of Resident #1's MAR for June 2021 revealed: -There was an entry for budesonide-formoterol 80-4.5mg inhale 2 puffs 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 06/01/21 to 06/01/21. Review of Resident #1's MAR for July 2021 revealed: -There was an entry for budesonide-formoterol 80-4.5mg inhale 2 puffs 2 times daily scheduled for 8:00am. -The 8:00pm dose was not listed on the MAR. -All morning doses had been documented as administered 07/01/21 - 07/23/21. -There was no documentation the 8:00pm dose had been administered from 07/01/21 - 07/23/21. Observation of Resident #1's medication on hand on 07/23/21 at 4:22pm revealed: -There were 2 budesonide-formoterol inhalers available. -Both inhalers remained new in the box and the boxes were sealed. -One inhaler had a dispense date of 10/13/20 and	C 330		

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C 330	Continued From page 10 the other had a dispense date of 11/20/20. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/28/21 at 9:54am revealed: -Resident #1 had difficulty obtaining budesonide-formoterol 80-4.5mg inhaler due to insurance issues. -The pharmacy representative had informed the PCP of Resident #1's insurance issues. -The budesonide-formoterol inhaler was dispensed on 10/13/20, 11/20/20, and 12/10/20. -The inhaler would last for one month if taken as directed. -Resident #1 used the inhaler to help control his asthma. Telephone interview with a Nurse for Resident #1's PCP on 07/28/21 at 10:06am revealed: -He did not know Resident #1 had difficulty with the co-pay for the budesonide-formoterol inhaler. -He ordered budesonide-formoterol inhaler to control his asthma. -Not receiving the budesonide-formoterol inhaler increased the residents' risk of breathing difficulty. Telephone interview with a SIC on 07/28/21 at 3:09pm revealed: -He thought the budesonide-formoterol inhaler was as needed. -The other SIC administered the medications. -He thought the other SIC had informed the PCP of Resident #1's inability to pay for his budesonide-formoterol inhaler. -He did not audit the MARs to ensure medications were administered. Telephone interview with the Administrator on 07/28/21 at 3:26pm revealed:	C 330		

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C 330	Continued From page 11 -She believed Resident #1 was administered his budesonide-formoterol inhaler. -Resident #1 had several budesonide-formoterol inhalers available. -She had checked the boxes and two of the 4 inhalers were empty, but the two she had on hand were dispensed on 10/13/20 and 11/20/20 and had not been used. -Resident #1 had to switch PCPs due to difficulty obtaining appointments with the former PCP. -Resident #1 refused his budesonide-formoterol inhaler but it should have been written on the back of the MAR. -The second SIC was supped to ensure the MARs were correct. Attempted interview with Resident #1 on 07/27/21 at 9:45 am was unsuccessful. b. Review of Resident #1's current FL2 dated 06/11/21 revealed there was an order for omega-3 ethyl esters (used to treat high triglycerides) 1g twice daily. Review of Resident #1's medication administration record (MAR) for May 2021 revealed: -There was an entry for omega-3 1g 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 05/01/21 to 05/31/21. Review of Resident #1's MAR for June 2021 revealed: -There was an entry for omega-3 1g 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 06/01/21 to 06/30/21.	C 330		

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C 330	Continued From page 12 Review of Resident #1's MAR for July 2021 revealed: -There was an entry for omega-3 1g 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 07/01/21 to 07/23/21 at 8:00am. Observation of Resident #1's medications on hand on 07/23/21 at 4:22pm revealed there was no omega-3 available. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/28/21 at 9:54am revealed: -Resident #1 had difficulty obtaining omega-3 1g capsules due to high co-pays. -Resident #1's guardian would not pay the co-pay for omega-3. -The last prescription for omega-3 was received on 04/21/21, but it had not been filled since 02/21/21. -The omega-3 would last for one month if taken as directed. -Resident #1 used omega-3 to reduce triglycerides. -Not receiving omega-3 as directed would decrease the effectiveness of the medication. Telephone interview with a Nurse with Resident #1's Primary Care Provider (PCP) on 07/28/21 at 10:06am revealed: -He did not know Resident #1 had difficulty with the co-pay for the omega-3 1g capsules. -He ordered omega-3 1g capsules to help decrease Resident #1's triglyceride level. Telephone interview with a Supervisor-in-Charge (SIC) on 07/28/21 at 3:57pm revealed:	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032062	A. BUILDING: _____ B. WING _____	R 07/28/2021

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C 330	Continued From page 13 -Resident #1 only used omega-3 when he wanted to when it was available. -She did not know why she documented that Resident #1 had taken omega-3. -She did not recall the last time Resident #1 had omega-3. Telephone interview with the Administrator on 07/28/21 at 3:26pm revealed: -She believed Resident #1 was administered his omega-3. -Resident #1 had a partial bottle of omega-3. -Resident #1 had to switch PCP's due to difficulty obtaining appointments with the former PCP. -Resident #1 refused his omega-3 but it should have been written on the back of the MAR. -The second SIC was responsible to ensure the MAR's were correct. Attempted interview with Resident #1 on 07/27/21 at 9:45 am was unsuccessful. 2. Review of Resident #3's current FL2 dated 04/30/21 revealed diagnoses included schizoaffective disorder bipolar type and chron's disease. a. Review of Resident #3's current FL2 dated 04/30/21 revealed there was an order for fluticasone (used to rhinitis) 50mg nasal spray 1 spray into each nostril twice daily. Observation of Resident #3's medications on hand on 07/23/21 at 4:00pm revealed: -There were 2 bottles of fluticasone on hand. -Both bottles remained new in the box and the boxes were sealed. -One bottle was dispensed on 03/10/20 and the second bottle was dispensed on 09/01/20.	C 330		

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C 330	Continued From page 14 Review of Resident #3's medication administration record (MAR) for May 2021 revealed: -There was an entry for fluticasone 50mg nasal spray 1 spray into each nostril twice daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 05/01/21 to 05/31/21. Review of Resident #3's MAR for June 2021 revealed: -There was an entry for fluticasone 50mg nasal spray 1 spray into each nostril twice daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 06/01/21 to 06/30/21. Review of Resident #3's MAR for July 2021 revealed: -There was an entry for fluticasone 50mg nasal spray 1 spray into each nostril twice daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm through 8:00am from 07/01/21 to 07/23/21. Telephone interview with the representative at Resident #3's contracted pharmacy on 07/28/21 at 12:59pm revealed: -Resident #3's fluticasone was last filled and dispensed on 09/21/20. -Resident #3's fluticasone had not had any refills this year. -Resident #3's fluticasone should last 30 days if administered as directed. -Fluticasone was not automatically sent to the facility; it had to be requested by staff monthly.	C 330		

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C 330	Continued From page 15 Interview with Resident #3 on 07/27/21 at 2:55 pm revealed he had not been administered his nasal spray in a long time. Interview with a Supervisor-in-Charge (SIC) on 07/27/21 at 10:17am revealed: -She thought Resident #3's fluticasone was as needed. -She must have not read the order correctly. -Resident #3 did not refuse the fluticasone but only used it when he needed it. -She had not asked the primary care provider (PCP) for a clarification of the order. -She was responsible for administering medications as ordered. Interview with the Administrator on 07/27/21 at 3:55pm revealed: -She spoke with Resident #3 yesterday. -Resident #3 said he had not been using his fluticasone because he did not want it. -The SIC was responsible for administering medications as ordered. Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:43pm was unsuccessful. b. Review of Resident #3's current FL2 dated 04/30/21 revealed there was an order for lidocaine patches (used to treat pain) 5% apply 2 patches to skin daily for 12 hours then remove. Review of Resident #3's MAR for May 2021 revealed: -There was an entry for lidocaine patches 5% apply 2 patches to skin daily for 12 hours then remove, scheduled for application at 8:00am and removal at 8:00pm. -There was documentation all patches had been applied at 8:00am and removed 8:00pm from	C 330		

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C 330	Continued From page 16 05/01/21 to 05/31/21. Review of Resident #3's MAR for June 2021 revealed: -There was not an entry for lidocaine patches 5% apply 2 patches to skin daily for 12 hours then remove, scheduled for application at 8:00am and removal at 8:00pm. -There was no documentation all doses had been applied at 8:00am and removed at 8:00pm from 06/01/21 to 06/30/21. Review of Resident #3's MAR for July 2021 revealed: -There was not an entry for lidocaine patches 5% apply 2 patches to skin daily for 12 hours then remove, scheduled for application at 8:00am and removal at 8:00pm. -There was no documentation all doses had been applied at 8:00am and removed at 8:00pm from 07/01/21 to 07/23/21 at 8:00am. Observation of Resident #3's medications on hand on 07/23/21 at 4:00pm revealed: -There were 2 unopened boxes of lidocaine patches 5% with a quantity of 30 patches. -The boxes of lidocaine patches were dispensed on 09/21/20 and 06/04/21. Telephone interview with the representative at Resident #3's contracted pharmacy on 07/28/21 at 12:59pm revealed: -Resident #3's lidocaine patches were filled and dispensed on 09/21/20 and 06/04/21. -Resident #3's lidocaine patches should last 30 days if administered as directed. - Lidocaine patches were not automatically sent to the facility; they had to be requested by staff monthly.	C 330		

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C 330	Continued From page 17 Interview with Resident #3 on 07/27/21 at 2:55 pm revealed: -Staff had not been giving him his pain patches until this past weekend (Saturday and Sunday) but he did not get them Monday or today. -The patches were prescribed for pain in his lower back. -When the patches were not administered, he had an increase in low back and spinal pain as well as muscle spasms in his low back. Interview with a Supervisor-in-Charge (SIC) on 07/27/21 at 10:17am revealed: -She thought Resident #3 lidocaine patches were as needed. -She must have not read the order correctly. -Resident #3 did not refuse the patches but only used them when he needed them. -She had not asked the PCP for a clarification of the order. -She was responsible for administering medications as ordered. Interview with another SIC on 07/27/21 at 10:50am revealed Resident #3 did not use lidocaine patches very often, so he sent a clarification to the primary care provider (PCP) on 07/23/21 to see if the lidocaine patches could be changed to as needed. Interview with the Administrator on 07/27/21 at 3:55pm revealed: -She spoke with Resident #3 yesterday. -Resident #3 said he had not been getting his pain patches but added he did get them over the weekend. -The SIC was responsible for administering medications as ordered. Attempted telephone interview with Resident #3's	C 330		

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C 330	Continued From page 18 PCP on 07/28/21 at 1:43pm was unsuccessful. c. Review of Resident #3's current FL2 dated 04/30/21 revealed there was an order for nicotine patches (used to treat nicotine addiction) 7mg apply daily and remove old patch. Review of Resident #3's MAR for May 2021 revealed: -There was an entry for nicotine patches 7mg apply 1 patch apply daily and remove old patch scheduled for application at 8:00am. -There was documentation all patches had been applied at 8:00am from 05/01/21 to 05/31/21. Review of Resident #3's MAR for June 2021 revealed: -There was not an entry for a nicotine patch 7mg apply 1 patch apply daily and remove old patch scheduled for application at 8:00am. -There was no documentation a patch had been applied at 8:00am from 06/01/21 to 06/30/21. Review of Resident #3's MAR for July 2021 revealed: -There was not an entry for a nicotine patch 7mg apply 1 patch apply daily and remove old patch scheduled for application at 8:00am. -There was no documentation a patch had been applied at 8:00am from 07/01/21 to 07/23/21. Observation of Resident #3's medications on hand on 07/23/21 at 4:00pm revealed: -There were 2 unopened boxes of nicotine patches with a quantity of 14 patches in each box. -The box of nicotine patches was dispensed on 05/20/21 and the other on 7/21/21. Telephone interview with the representative at Resident #3's contracted pharmacy on 07/28/21	C 330		

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C 330	Continued From page 19 at 12:59pm revealed: -Resident #3's nicotine patches were last filled and dispensed on 07/21/21. -Resident #3's nicotine patches should last 14 days if administered as directed. - Nicotine patches were not automatically sent to the facility; they had to be requested by staff monthly. Interview with Resident #3 on 07/27/21 at 2:55 pm revealed: -He smoked cigarettes and had wanted to stop. -He thought the physician gave him some patches to help him quit smoking, but he had not been administered any nicotine patches. Interview with a Supervisor-in-Charge (SIC) on 07/27/21 at 10:17am revealed: -She thought Resident #3's nicotine patches were as needed. -She must have not read the order correctly. -Resident #3 did not refuse the patches but only used them when he needed them. -She had not asked the primary care provider (PCP) for a clarification of the order. -She was responsible for administering medications as ordered. Interview with the Administrator on 07/27/21 at 3:55pm revealed: -She spoke with Resident #3 yesterday. -Resident #3 said he had not been using his nicotine patches because he did not want them. -The SIC was responsible for administering medications as ordered. Attempted telephone interview with Resident #3's PCP on 07/28/21 at 1:43pm was unsuccessful. _____ The facility failed to administer medications as	C 330		

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C 330	Continued From page 20 ordered for 2 of 3 sampled residents (#1 and #3) which placed a resident at increased risk for breathing difficulty (#1) who had a diagnosis of asthma; and increased risk of pain (#3) who had a diagnosis of chron's disease. The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/23/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 18, 2021	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	C 342		

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C 342	Continued From page 21 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 2 of 3 sampled residents (Resident #1 and #3). The findings are: 1. Review of Resident #1's current FL2 dated 06/11/21 revealed diagnoses included schizophrenia. a. Review of Resident #1's current FL2 dated 06/11/21 revealed there was an order for budesonide-formoterol (used for treatment of asthma) 80-4.5mg inhale 2 puffs 2 times daily. Review of Resident #1's medication administration record (MAR) for May 2021 revealed: -There was an entry for budesonide-formoterol 80-4.5mg inhale 2 puffs 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 05/01/21 to 05/31/21. Review of Resident #1's MAR for June 2021 revealed: -There was an entry for budesonide-formoterol 80-4.5mg inhale 2 puffs 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from	C 342		

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C 342	Continued From page 22 06/01/21 to 06/30/21. Review of Resident #1's MAR for July 2021 revealed: -There was an entry for budesonide-formoterol 80-4.5mg inhale 2 puffs 2 times daily scheduled for 8:00am. -The 8:00pm dose was not listed on the MAR. -All morning doses had been documented as administered from 07/01/21 to 07/23/21. -There was no documentation the 8:00pm dose had been administered from 07/01/21 to 07/23/21. Observation of Resident #1's medication on hand on 07/23/21 at 4:22pm revealed: -There were 2 budesonide-formoterol inhalers available. -Both inhalers remained new in the box and the boxes were sealed. -One inhaler had a dispense date of 10/13/20 and the other had a dispense date of 11/20/20. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/28/21 at 9:54am revealed: -The budesonide-formoterol inhaler was dispensed on 10/13/20, 11/20/20, and on 12/10/20. -The inhaler would last for one month if taken as directed. Telephone interview with a Supervisor-in-Charge (SIC) on 07/28/21 at 3:57pm revealed: -She did not know she had left the 8:00pm dose of budesonide-formoterol inhaler off the July 2021 MAR. -She did not know why she did not document that he did not use the inhaler on days he did not use it.	C 342		

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C 342	Continued From page 23 -She did not recall the last time Resident #1 used the budesonide-formoterol inhaler. Telephone interview with the Administrator on 07/28/21 at 3:26pm revealed: -She believed Resident #1 was administered his budesonide-formoterol inhaler. -Resident #1 had several budesonide-formoterol inhalers available. -She had checked the boxes and two of the 4 inhalers were empty, but the two she had on hand were dispensed on 10/13/20 and 11/20/20. -Resident #1 refused his budesonide-formoterol inhaler but it should have been written on the back of the MAR. Refer to interview with a SIC on 07/27/21 at 10:17am. Refer to interview with another SIC on 07/27/21 at 10:15am. Refer to interview with the Administrator on 07/27/21 at 1:31 pm. b. Review of Resident #1's current FL2 dated 06/11/21 revealed there was an order for omega-3 ethyl esters (used to treat high triglycerides) 1g twice daily. Review of Resident #1's MAR for May 2021 revealed: -There was an entry for omega-3 1g 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm. -Based on the medication on hand, dispense dates, and interview with the contracted pharmacy, it was determined that the medication could not have been administered daily even	C 342		

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C 342	Continued From page 24 though the medication had been marked as administered, thereby making the MAR inaccurate. Review of Resident #1's MAR for June 2021 revealed: -There was an entry for omega-3 1g 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 05/01/21 to 05/31/21. Review of Resident #1's MAR for July 2021 revealed: -There was an entry for omega-3 1g 2 times daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 07/01/21 to 07/23/21 at 8:00am. Observation of Resident #1's medications on hand on 07/23/21 at 4:22pm revealed there was no omega-3 available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/28/21 at 9:54am revealed: -The last prescription for omega-3 was received on 04/21/21 but it had not been dispensed since 02/21/21. -The omega-3 would last for one month if taken as directed. Telephone interview with a Supervisor-in-Charge (SIC) on 07/28/21 at 3:57pm revealed: -Resident #1 only took omega-3 when he wanted to when it was available. -She did not know why she documented that Resident #1 had taken omega-3. -She did not recall the last time Resident #1 had	C 342		

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C 342	Continued From page 25 omega-3. Telephone interview with the Administrator on 07/28/21 at 3:26pm revealed: -She thought Resident #1 was administered his omega-3. -Resident #1 refused his omega-3 but it should have been written on the back of the MAR. -The second SIC was supposed to ensure the MAR's were correct. Refer to interview with a SIC on 07/27/21 at 10:17am. Refer to interview with another SIC on 07/27/21 at 10:15am. Refer to interview with the Administrator on 07/27/21 at 1:31 pm. 2. Review of Resident #3's current FL2 dated 04/30/21 revealed diagnoses included schizoaffective disorder bipolar type and chrons disease. a. Review of Resident #3's current FL2 dated 04/30/21 revealed there was an order for fluticasone (used to rhinitis) 50mg nasal spray 1 spray into each nostril twice daily. Review of Resident #3's MAR for May 2021 revealed: -There was an entry for fluticasone 50mg nasal spray 1 spray into each nostril twice daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 05/01/21 to 05/31/21. Review of Resident #3's MAR for June 2021	C 342		

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C 342	Continued From page 26 revealed: -There was an entry for fluticasone 50mg nasal spray 1 spray into each nostril twice daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 06/01/21 to 06/30/21. Review of Resident #3's MAR for July 2021 revealed: -There was an entry for fluticasone 50mg nasal spray 1 spray into each nostril twice daily scheduled for 8:00am and 8:00pm. -There was documentation all doses had been administered for 8:00am and 8:00pm from 07/01/21 to 8:00am on 07/23/21. Observation of Resident #3's medications on hand on 07/23/21 at 4:00pm revealed: -There were 2 bottles of fluticasone on hand. -Both bottles remained new in the box and the boxes were sealed. -One bottle was dispensed on 03/10/20 and the second bottle was dispensed on 09/01/20. Telephone interview with the representative at Resident #3's contracted pharmacy on 07/28/21 at 12:59pm revealed: -Resident #3's fluticasone was last filled and dispensed on 09/21/20. -Resident #3's fluticasone had not had any refills on fluticasone this year. -Resident #3's fluticasone should last 30 days if administered as directed. -Fluticasone was not automatically sent to the facility; it had to be requested by staff monthly. Interview with Resident #3 on 07/27/21 at 2:55 pm revealed he had not been administered his nasal spray in a long time.	C 342		

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C 342	Continued From page 27 Interview with a Supervisor-in-Charge (SIC) on 07/27/21 at 10:17am revealed: -She thought Resident #3's fluticasone was as needed. -She must have not read the order correctly. -Resident #3 did not refuse the fluticasone but only used it when he needed it. Interview with the Administrator on 07/27/21 at 3:55pm revealed: -She spoke with Resident #3 yesterday. -Resident #3 said he had not been using his fluticasone because he did not want it. Refer to interview with a SIC on 07/27/21 at 10:17am. Refer to interview with another SIC on 07/27/21 at 10:15am. Refer to interview with the Administrator on 07/27/21 at 1:31 pm. b. Review of Resident #3's current FL2 dated 04/30/21 revealed there was an order for lidocaine patches (used to treat pain) 5% apply 2 patches to skin daily for 12 hours then remove. Review of Resident #3's MAR for May 2021 revealed: -There was an entry for lidocaine patches 5% apply 2 patches to skin daily for 12 hours then remove, scheduled for application at 8:00am and removal at 8:00pm. -There was documentation all patches had been applied at 8:00am and removed 8:00pm from 05/01/21 to 05/31/21. Review of Resident #3's MARs for June 2021 and	C 342		

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C 342	Continued From page 28 July 2021 revealed there was not an entry for lidocaine patches 5% apply 2 patches to skin daily for 12 hours then remove. Observation of Resident #3's medications on hand on 07/23/21 at 4:00pm revealed: -There were 2 unopened boxes of lidocaine patches 5% with a quantity of 30 patches. -The boxes of lidocaine patches were dispensed on 09/21/20 and on 06/04/21. Telephone interview with the representative at Resident #3's contracted pharmacy on 07/28/21 at 12:59pm revealed: -Resident #3's lidocaine patches were filled and dispensed on 09/21/20 and 06/04/21. -Resident #3's lidocaine patches should last 30 days if administered as directed. - Lidocaine patches were not automatically sent to the facility; they had to be requested by staff monthly. Interview with Resident #3 on 07/27/21 at 2:55 pm revealed staff had not been giving him his pain patches until this past weekend (Saturday and Sunday) but did not get them Monday or today. Interview with a Supervisor-in-Charge (SIC) on 07/27/21 at 10:17am revealed: -She thought Resident #3's lidocaine patches were as needed. -She must have not read the order correctly. -Resident #3 did not refuse the patches but only used them when he needed them. Interview with the Administrator on 07/27/21 at 3:55pm revealed: -She spoke with Resident #3 yesterday. -Resident #3 said he had not been getting his	C 342		

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C 342	Continued From page 29 pain patches but added he did get them over the weekend. Refer to interview with a SIC on 07/27/21 at 10:17am. Refer to interview with another SIC on 07/27/21 at 10:15am. Refer to interview with the Administrator on 07/27/21 at 1:31 pm. c. Review of Resident #3's current FL2 dated 04/30/21 revealed there was an order for nicotine patches (used to treat nicotine addiction) 7mg apply daily and remove old patch. Review of Resident #3's MAR for May 2021 revealed: -There was an entry for nicotine patches 7mg apply 1 patch apply daily and remove old patch scheduled for application at 8:00am. -There was documentation all patches had been applied at 8:00am from 05/01/21 to 05/31/21. Review of Resident #3's MARs for June 2021 and July 2012 revealed there was not an entry for a nicotine patch 7mg apply 1 patch apply daily and remove old patch. Observation of Resident #3's medications on hand on 07/23/21 at 4:00pm revealed: -There were 2 unopened boxes of nicotine patches with a quantity of 14 patches in each box. -The box of nicotine patches was dispensed on 05/20/21 and on 7/21/21. Telephone interview with the representative at Resident #3's contracted pharmacy on 07/28/21 at 12:59pm revealed:	C 342		

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C 342	Continued From page 30 -Resident #3's nicotine patches were last filled and dispensed on 07/21/21. -Resident #3's nicotine patches should last 14 days if administered as directed. - Nicotine patches were not automatically sent to the facility; they had to be requested by staff monthly. Interview with Resident #3 on 07/27/21 at 2:55 pm revealed he had not been administered any nicotine patches. Interview with a Supervisor-in -Charge (SIC) on 07/27/21 at 10:17am revealed: -She thought Resident #3's nicotine patches were as needed. -She must have not read the order correctly. -Resident #3 did not refuse the patches but only used them when he needed them. Interview with the Administrator on 07/27/21 at 3:55pm revealed: -She spoke with Resident #3 yesterday. -Resident #3 said he had not been using his nicotine patches because he did not want them. Refer to interview with a SIC on 07/27/21 at 10:17am. Refer to interview with another SIC on 07/27/21 at 10:15am. Refer to interview with the Administrator on 07/27/21 at 1:31 pm. Interview with a SIC on 07/27/21 at 10:17am revealed: -She did not know she had left medications off the MAR. She did not know she had signed off medications	C 342		

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C 342	Continued From page 31 that were not given. -She used the FL2 to create a MAR for a new resident. -If the residents used the contracted pharmacy, they would send a MAR the following month. -She hand wrote some MARs monthly because some residents did not use the contracted pharmacy. -She only compared the medications to the MAR on admission. -She did not use the MARs to administer medications to the residents. -She went through the medication containers to pull the residents medications and then documented on the MAR after she administered that residents' medications. -She did not know she left medications off the MARs because she did not review them monthly. -The other SIC was supposed to review the MAR to make sure it was correct. Interview with another SIC on 07/27/21 at 10:15am revealed: -The other SIC made the MARs. -He did not check behind the other SIC to ensure all medications were on the MAR correctly. -Some MARs had to be hand printed because the contracted pharmacy will not print MARs for residents that do not get their medication from them. Interview with the Administrator on 07/27/21 at 1:31 pm revealed: -She reviewed all the MARs and the records on 07/24/221 and 07/25/21 to ensure the MARs were correct. -The SICs were responsible to ensure the MARs were accurate.	C 342		

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C 375	Continued From page 32	C 375		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmaceutical	C 375		

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C 375	Continued From page 33 reviews were completed for 2 of 3 sampled residents (#1 and #3). The findings are: 1. Review of Resident #1's current FL2 dated 06/11/21 revealed diagnoses included schizophrenia. Review of Resident #1's record revealed there was no pharmacy reviews available for review. Refer to interview with the Administrator on 07/27/21 at 3:55pm. Refer to the telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/28/21 at 10:24pm. 2. Review of Resident #3's current FL2 dated 04/30/21 revealed diagnoses included schizoaffective disorder bipolar type and chron's disease. Review of Resident #3's record revealed there were no pharmacy reviews since 12/20/19. Refer to interview with the Administrator on 07/27/21 at 3:55pm. Refer to the telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/28/21 at 10:24pm. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/28/21 at 10:24pm revealed: -The last reviews the pharmacy had completed for the facility were completed on 03/24/20. -The pharmacy will not complete pharmacy	C 375		

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C 375	Continued From page 34 reviews for veterans because they were not able to verify their medication orders. -They informed the Administrator that they would not be able to complete the pharmacy reviews and she said she would find someone else to do them. Interview with the Administrator on 07/27/21 at 3:55pm revealed: -Medication reviews had not been completed for the year 2020 or 2021. -The contracted pharmacy would not complete medication reviews for veterans because they were unable to verify their prescriptions. -She had spoken to another pharmacy in March 2021 and they said they could start completing the pharmacy reviews for the facility, but they would not be able to come on site and do them due to COVID-19. -They requested for her to send the information to complete the reviews, but she had not sent it (did not say why). -She was responsible for ensuring the pharmacy reviews were completed.	C 375		
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 review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant	C 912		

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C 912	Continued From page 35 federal and state laws and rules and regulations related to supervision and medication administration. The findings are: 1. Based on interviews and record reviews the facility failed to provide supervision for 1 of 3 sampled residents (Resident #1) who eloped twice from the facility. [Refer to Tag 243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) including a medication used to prevent wheezing and shortness of breath and a medication used to lower triglycerides (Resident #1) and a medication used to treat rhinitis, pain, and a chemical dependence (Resident #3). [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 912		

Sept. 9, 2021

Jo Scarlett, RN Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Barbara Bright, Administrator/Licensee
BJ's Family Care Home
716 Hugo Street
Durham, NC 27704

FCL-032-062

Email: barbra.bright@yahoo.com

Re: Annual and Follow Correction Survey completed July 28, 2021
Type B Violations

C243 10A NCAC 13G .0901(b) Personal Care and Supervision
(b) Staff shall provide supervision of residents in accordance with each residents assessed needs, care plan and current symptoms.

Plan of Correction: C243

1. Staff has been given training in the area of Personal Care & Supervision addressing supervision of residents in accordance with each residents assessed needs, care plan and current symptoms. 7/27/21

2. Staff will be given training twice a year or as needed to prevent the problem from occuring again. 7/27/21

3. The home SrLC will monitor the situation to ensure it will not occure again.

4. The SrLC will monitor the situation as needed or as often or required to ensure it will not happen again. 7/27/2021

5. Completion dates the plan will be completed 8/18/2021

C330 10A NCAC 13G .1004(a) Medication Administration

.1004(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 residents record; and
(2) rules in this Section and the facility's policies and procedures

C330 1. The current policy & procedure was reviewed by the home administrator no changes to policy and procedures warranted at this time. Administrator identified that current staff needs to be re-trained in the area of medication administration.

2. Staff training in medication administration will be given to prevent the problem from occurring again.

3. The home RN Nurse will monitor the situation to ensure it will not occur again. 4. She will monitor the situation quarterly to ensure the problem in medication administration does not occur again. 8/18/2021 Completion Date

BBright, Adm

C342 10A NCAC 13G. 1004 Medication Administration
(J) The resident's medication administration record (MAR) shall be accurate and include the following 1-8.

1. Staff training will be given to all staff in the area medication administration record (MAR). To prevent the problem from occurring again
2. The home RN Nurse will monitor the situation quarterly to ensure the situation does not occur again. Training will be completed by 9/30/2021

BBright, Adm.

C375 10A NCAC 13G .1009 (a)(1) Pharmaceutical Care

1. Hired new pharmacy; Pharmacy will provide quarterly medication/pharmacy review to prevent problem from reoccurring again. The home DTC and administrator will monitor the pharmacy review quarterly to ensure quarterly review has been completed. Complete date of correction is 9/30/2021

BBright, Adm.

C912 ~~10A NCAC 13G~~. G.S. 131D-21 (2) Declaration of Residents' Rights
@@ 9/9/2021

1. Upon review by home administrator the staff need to be trained in the area of Residents' Rights
2. Staff will be given training in the area of Residents' Right to ensure that every resident shall have the following rights: (2) To receive care and supervision which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

Continued

3. The home administrator will monitor the situation with monthly or as needed or required to ensure problem does not occur again. Completion of plan will be: 9/30/2021 BBright, Adm.