

Division of Health Service Regulation

Received via email 02-14-22, KHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
(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 completed a complaint investigation on 12/13/21 through 12/14/21.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) was tested for tuberculosis (TB) disease upon hire. The findings are: Review of Staff A's, Supervisor-In-Charge/medication aide (SIC/MA) personnel record revealed: -There was no hire date listed for Staff A. -There was no documentation that an initial TB skin test was placed or read.	C 140	All staff will have a - 12/16/21 negative TB test upon being hired and must receive a 2nd step TB test within 3 weeks of hire. The Administrator will ensure that all staff have the required testing for employment and placed in the staff file for immediate review. Administrator will check records on a monthly basis for compliance.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Hazel Faerman - Administrator 1/28/22

STATE FORM

8899

QE2411

If continuation sheet 1 of 94

Acknowledged and Accepted 02/14/22 KHH

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C 140	Continued From page 1 -There was no documentation that Staff A had a second TB skin test placed or read. Interview with Staff A on 12/13/21 at 9:47am revealed: -She started working at the facility in June 2021. -She was unable to recall the exact date she started working, but thought it was around the 19th or 20th of the month of June 2021. -She did not have a TB skin test placed when she started to work at the facility because she did not know she needed one. -She previously worked at the facility and thought the previous TB skin test from 2014 was good. Telephone interview with the Acting Administrator on 12/14/21 at 11:09am revealed: -She was not aware Staff A had not completed an initial TB skin test or a second TB skin test. -Staff A worked at the facility as the live-in SIC/MA. -When she took over the operations of the facility in July 2021, Staff A was already employed at the facility. -She did not check Staff A's personnel record to ensure the required TB skin tests were completed because she thought that had been taken care of by the previous owner. -She had not designated a person to be responsible for checking Staff A's personnel's record for a TB skin test because she did not hire Staff A.	C 140			
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall:	C 147			

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C 147	Continued From page 2 (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had a statewide criminal background check completed upon hire. The findings are: Review of Staff A's, Supervisor-In-Charge/medication aide (SIC/MA) personnel record revealed: -There was no hire dated documented for Staff A. -There was no documentation of a statewide criminal background check completed upon hire for Staff A or a signed consent for a background check available for review. Interview with Staff A on 12/14/21 at 9:47am revealed: -She had worked at the facility as the live-in Supervisor-In-Charge/medication aide (SIC/MA) since June 2021. -When started working in June 2021, no criminal background check was completed on her. -She had previously worked at the facility in 2014 and thought her old paperwork was good. Telephone interview with the Acting Administrator on 12/14/21 at 11:09am revealed: -When she took over the operations of the facility in July 2021, Staff A was already employed at the facility. -She thought a criminal background had already been completed on Staff A. -She did not check Staff A's personnel record to ensure a criminal background check was	C 147	Administrator Will ensure all staff obtain a criminal background check prior to beginning work at the home. Administrator will review records on a monthly basis to ensure compliance is maintained.	12/16/21

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C 147	Continued From page 3 completed because she did not hire Staff A. -Staff A worked at the facility seven days per week, twenty-four hours per day as the SIC/MA. -She had not designated a person to be responsible for checking and ensuring staff had a criminal background check because she thought Staff A's criminal background check had been completed by the previous owner.	C 147		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had completed a competency validation for Licensed Health Professional Support (LHPS) for tasks of administering medication by injection and monitoring fingerstick blood sugar (FSBS). The findings are: Review of Staff A's,	C 171		2/16/21 All staff will have a LHPS checklist completed by licensed professional prior to performing task at the home. Administrator will review staff records →

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C 171	Continued From page 4 Supervisor-in-Charge/medication aide (S-C/MA) personnel record revealed: -There was no hire date documented for Staff A. -There was no documentation Staff A had completed a competency validation for LHPS tasks. Review of 6 resident's electronic medication administration (eMAR) record for October, November and December 2021 revealed -Staff A documented Fingertick Blood Sugars (FSBS) results and administering sliding scale insulin most days, three times per day for two residents. -Staff A documented administration of medications on the eMAR on 22 days from 10/01/21 through 10/31/21. -On 24 days from 11/01/21 through 11/30/21. -On 13 days from 12/01/21 through 12/13/21. Interview with a resident on 12/14/21 at 10:45am revealed most days Staff A checked his FSBS and sometimes administered insulin. Interview with Staff A on 12/14/21 at 9:47am revealed: -There were two residents who had physician's orders to check FSBS and one resident was administered insulin. -She checked the resident's FSBS and administered insulin to the resident three times daily. -She had not been checked off by a nurse for competency validation for LHPS tasks. Telephone interview with the Acting Administrator on 12/14/21 at 11:09am revealed: -She was not aware Staff A had not completed LHPS competency validations. -She thought Staff A had completed a LHPS	C 171	on a monthly basis to ensure / maintain compliance.	

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C 171	Continued From page 5 competency validation. -Staff A was employed at the facility prior to her taking over the operations of the facility. -Staff A checked FSBS for two residents and administered insulin daily for another resident. -She had not made anyone responsible for checking and ensuring LHPS competencies were completed for staff because she did not hire Staff A. -She thought the previous owner had completed Staff A's LHPS competency validation.	C 171		
C 174	10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents 10A NCAC 13G .0505 Training On Care Of Diabetic Residents A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; appropriate administration times; and (g) sliding scale insulin administration.	C 174	<i>12/16/21</i> <i>All staff will have the appropriate training and documentation for diabetic residents completed prior to performing the task done by the appropriate personnel.</i> <i>Administrator will review staff records on a monthly basis to ensure and maintain compliance.</i>	

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C 174	Continued From page 6 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff, (Staff A), had completed training on the care of a diabetic resident prior to the administration of insulin. The findings are: Review of Staff A's, Supervisor-in-Charge/medication aide (SIC/MA), personnel record revealed: -There was no documented date of hire for Staff A. -There was no documentation of completion of training on care of diabetic residents. Review of a resident's electronic medication administration record (eMAR) for October November and December 2021 revealed Staff A documented Fingerstick Blood Sugar (FSBS) results and administering insulin in 16 days in October 2021, 18 days in November 2021, and 12 days in December 2021. Interview with Staff A on 12/14/21 at 9:47am revealed: -She started working at the facility in June 2021. -She had not received training on the care of diabetic residents. -She checked at least two resident's FSBS, one three times daily and another once a week. -She administered insulin daily to one resident. Telephone interview with the Acting Administrator on 12/14/21 at 11:09am revealed: -She was not aware Staff A had not completed diabetic care training. -She thought Staff A had completed all the	C 174		

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C 174	Continued From page 7 required trainings. -Staff A was responsible for checking the FSBS of two residents at the facility. -She took over operations of the facility in July 2021, and she did not check Staff A's personnel record because she thought the previous owner made sure the required trainings were completed. -She had not assigned any one to be responsible for ensuring staff completed diabetic training because she did not hire Staff A.	C 174		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601 Management and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations the Administrator failed to ensure the management and total operations of the facility were maintained to ensure compliance with the rules and statutes of adult care homes to	C 185	Administrator will ensure that all staff have all required documents for the position being offered to them for the home. Administrator will perform monthly record reviews to ensure maintain compliance of all records.	12/14/21

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C 185	Continued From page 8 protect each resident's rights to receive adequate and appropriate care and services related to test for tuberculosis, other staff qualifications, competency validation for licensed health, training on care of diabetic residents, health care, licensed health professional support, nutrition and food service, residents' right, medication orders, medication administration, health care personnel registry, controlled substance, Adult Care Homes medication aides training and competency, and examination and screening for controlled substances. The findings are: Telephone interview with the Acting Administrator (AA) on 12/14/21 at 4:58pm revealed: -She took over ownership of the facility at the beginning of July 2021. -The Administrator/Owner listed on the current license for the facility relinquished the license and gave total ownership of the facility to her. -She had completed paperwork to change the ownership of the facility to her in September 2021. -The Administrator/Owner listed on the current license for the facility was not currently involved with any aspects of the facility. -She was responsible for the total operations of the facility. -The facility staff reported directly to her. -She was responsible for ensuring staff completed required trainings, testing and competencies. -She had not checked staff records to ensure staff had completed required trainings, testing and competencies because the only staff that she hired was the House Manager. -There was no system in place to ensure all staff completed the required trainings, testing and	C 185		

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C 185	Continued From page 9 competencies. -There was no system in place for checking behind the Supervisor-In-Charge/medication aide (SIC/MA) to ensure incoming orders were reviewed and compared with the medication on the current eMARs to identify new, changed or discontinued medications. -The residents had reported to her that a staff member verbally abused them. -She talked with the staff member and had the staff member to complete Residents' Rights training. -She had not visited the facility to ensure the staff member no longer yelled and cursed at residents. -She had not communicated with the residents at the facility to find out if the staff member continued to yell and curse at them. -She had not reported the staff member to the health care personnel registry because she did not think to report the staff. -The SIC/MA was responsible for contacting the providers and/or outside agencies to follow-up on required or suggested health care issues -There was no systems in place to ensure the SIC/MA followed-up on health care needs a required or suggested because she had not had time to put a system in place. -She tried to visit the facility at least once a month. Telephone interview with the Administrator/Owner listed on the current license for the facility, on 12/14/21 at 2:54pm revealed: -She had not been to the facility in months. -She had no idea what was happening at the facility. -She gave ownership of the facility to the AA on 07/01/21. -The AA was responsible for the total operations of the facility.	C 185		

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C 185	Continued From page 10 Telephone interview with the House Manager on 12/14/21 at 5:25pm revealed: -She had worked as the House Manager since the end of October 2021. -She was hired by the AA. -She reported directly to the AA. -The AA was responsible for the total operations of the facility and was responsible for ensuring staff had all the required trainings and testing. -The AA was responsible for checking behind the medication aide to ensure medications were administered as ordered. -All staff were to report concerns to the AA. -The AA visited the facility maybe once a month. Interview with the SIC/MA on 12/14/21 at 9:36am revealed: -The AA took over ownership of the facility in July 2021. -She reported directly to the AA if she had a problem or if she requested time off work -The AA visited the facility maybe once a month. Interview with a resident on 12/13/21 at 8:25am revealed that he saw the AA at the facility maybe every two weeks but was not sure. Interview with another resident on 12/13/21 at 8:46am revealed he stayed in his room a lot and was not sure of the last time he saw the AA at the facility. Interview with a third resident on 12/13/21 at 8:55am revealed he never saw the AA at the facility. Interview with a fourth resident on 12/13/21 at 9:13am revealed he was unsure how often the AA came to the facility, he thought maybe she visited	C 185		

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C 185	Continued From page 11 last week, but was not sure. Telephone interview with a resident's responsible party on 12/14/21 at 1:26pm revealed: -She had contacted the AA a couple of months ago (could not recall the date) and was unable to reach the AA by phone so she left a voicemail. -The AA had called her back and left a voicemail for her to try and arrange a time to meet to discuss the concerns. -They had not been able to have their meeting due to conflicting schedules so she was not able to address her concerns with the AA. Noncompliance was identified in the following rule areas: 1. Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) was tested for tuberculosis (TB) disease upon hire. [Refer to Tag 140, 10A NCAC 13G .0405(a) (5) Test for Tuberculosis (Standard Deficiency)]. 2. Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had a statewide criminal background check completed upon hire. [Refer to tag 147, 10A NCAC 13G .0406(a)(7) Other Staff Qualifications (Standard Deficiency).] 3. Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had completed a competency validation for Licensed Health Professional Support (LHPS) for tasks of administering medication by injection and monitoring fingerstick blood sugar (FSBS). [Refer to Tag 171, 10A NCAC 13G .0504(a) Competency Validation for Licensed Health Professional Support Tasks (Standard Deficiency).]	C 185		

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C 185	Continued From page 12 4. Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff, (Staff A), had completed training on the care of a diabetic resident prior to the administration of insulin. [Refer to Tag 174, 10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents (Standard Deficiency).] 5. Based on observations, interviews, and record reviews, the facility failed to contact the primary care provider (PCP) for 1 of 3 sampled residents (Resident #2) related to refusals of Finger Stick Blood Sugar (FSBS) checks and insulin. [Refer to Tag 246, 10A NCAC 13G .0902(b) Health Care (Standard Deficiency).] 6. Based on observations, interviews, and record review, the facility failed to ensure follow-up to a recommendation made by the Licensed Health Professional Support Nurse (LHPS) for 2 of 3 sampled residents (Residents #1 and #2) related to notifying the physician regarding obtaining parameters for fingerstick blood sugar (FSBS) results (#1), and for a glycated hemoglobin test (A1C) and to clarify the sliding scale (#2). Refer to Tag 255, 10A NCAC 13G .0903(d) Licensed Health Professional Support Task [(Standard Deficiency).] 7. Based on observations, interviews, and record reviews, the facility failed to offer or make snacks available to the residents three times a day. [Refer to Tag 272, 10A NCAC 13G .0904(d)(2) Nutrition and Food Service (Standard Deficiency).] 8. Based on observations and interviews, the facility failed to ensure fruit was served twice daily to residents including a serving of citrus juice or	C 185	12/16/21 Staff will provide meals as instructed by a registered dietician and on a daily basis and at the times specified by the nurses. Staff will serve 3 meals and three snacks per day, with no exceptions. Administrator will menus are current and up to date, as well as residents diets posted for staff.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 185	Continued From page 13 fruit. [Refer to Tag 274, 10A NCAC 13G .0904(d) (3)(B) Nutrition and Food Service (Standard Deficiency).] 9. Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered for 1 of 3 sampled residents (#3) with an order for chopped meats. [Refer to Tag 284, 10A NCAC 13G .0904(e)(4) Nutrition and Food Service (Standard Deficiency).] 10. Based on observations, interviews and record reviews, the facility failed to contact the primary care provider for clarification of medication orders for 2 of 3 sampled residents (Residents #1 and #2) related to sliding scale insulin without parameters, pain/fever medication that was enteric-coated or chewable (#2), and an N-methyl-D-aspartate receptor antagonist (#1). [Refer to Tag 315, 10A NCAC 13G .1002(a) Medication Orders (Standard Deficiency)] 11. 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 #1). [Refer to Tag 342, 10A NCAC 13G .1004(j) Medication Administration (Standard Deficiency).] 12. Based on observation, record reviews and interviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration and disposition of controlled substances for 2 of 3 sampled residents (Residents #2 and #3) who received narcotic anti-anxiety medications. [Refer to Tag 367, 10A NCAC 13G .1008(a) Controlled Substances (Standard Deficiency).] 13. Based on interviews and record reviews, the	C 185	Administrator will perform menu / diet checks weekly for two months, then monthly on going.	

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C 185	Continued From page 14 facility failed to submit a report of allegations of verbal abuse by Staff A to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations that Staff A cursed and yelled at residents. [Refer to Tag 42E Health Care Personnel Registry (Standard Deficiency).] 14. Based on interviews and record reviews, the facility failed to ensure 1 of 2 staff (Staff A) had an examination and screening for the presence of controlled substances completed upon hire. [Refer to Tag 992, G.S. 131D-45 Examination and Screening for the Presence of Controlled Substances Required for Applicants for Employment in Adult Care Homes (Standard Deficiency).] 15. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 4 sampled residents (Residents #2, #3 and #4) were treated with respect, dignity, and free of verbal abuse by Staff A who cursed and yelled at the residents. [Refer to Tag 311, 10A NCAC 13G .0909 Residents' Rights (Type B Violation).] 16. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (Residents #1, #2, and #3) related to insulin administration, an antibiotic, an expectorant, multi-vitamins and administered discontinued medications for blood pressure and a potassium supplement (#2), a resident not administered a receptor antagonist medication (#1), and a resident not administered an anti-anxiety medication and an anti-depressant medication (#3). [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation).]	C 185		

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C 185	Continued From page 15 17. Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) who administered medications to residents had completed the medication administration competency validation clinical skills checklist prior to administering medications to the residents. [Refer to Tag 935, G.S. 131D-4.5B(b) Act Medication Aides; Training and Competency Evaluation (Type B Violation).] The Acting Administrator failed to ensure the overall management and operations of the facility and failed to implement policies and procedures to maintain substantial compliance of rules and regulations governing family care homes; failed ensure Staff A administered medications as ordered, clarified medication orders, and followed up with the Primary Care Provider regarding refusal of FSBS and insulin for 3 of 3 sampled residents related to a resident with no parameters for sliding scale insulin, not administering insulin or obtaining FSBS, administering the incorrect units of insulin and refusal of insulin and FSBS which could result in the resident experiencing episodes of hypoglycemia or hyperglycemia, and an antibiotic and an expectorant to treat pneumonia after a hospitalization was not administered which could result in worsening of pneumonia symptoms, and continued to administer a blood pressure medication after being discontinued which could result in low or high blood pressures (#2); a resident not administered memantine which could result in confusion and inability to make decisions (#1); and a resident not receiving an anti-anxiety and anti-depressant medications which could result in increased anxiety and depression (#3); failed to ensure residents were treated with respect and dignity related to the Staff A observed loudly yelling at a resident with a diagnosis of mental	C 185		

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STATE FORM

6899

QE411

If continuation sheet 16 of 94

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C 185	Continued From page 16 disorders resulting in the resident becoming upset (#4); another resident reported Staff A yelled and cursed at him which caused him to sometimes refuse his medications (#2); Staff A yelling and cursing at a third resident making the resident feel he was not wanted (#3); failed to ensure Staff A who administered medications completed the medication administration competency validation clinical skills checklist prior to administering medications resulting in errors in medication administration; and the Acting Administrator failed to ensure there were systems in place for the overall responsibilities and operations of the facility. The Acting Administrator's failure was detrimental to the residents' health, safety and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2022.	C 185		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to contact the primary care provider (PCP) for 1 of 3 sampled residents (Resident #2) related to refusals of Finger Stick Blood Sugar (FSBS) checks and insulin.	C 246	Staff will ensure that all paperwork received from doctors appointments and or from hospital discharge are reviewed immediately upon arrival and sent to the appropriate personnel for further review. Administrator will review all new orders and hospital discharge summaries on a weekly	12/16/21

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C 246	Continued From page 17 The findings are: Review of Resident #2's current FL2 dated 10/21/21 revealed: -Diagnoses included diabetes. -There was an order for Novolog 0-12 units three times daily with meals (fast-acting insulin used to control diabetes). Review of Resident #2's previous physician's order sheet dated 07/30/21 revealed: -There was an order for Novolog sliding scale insulin with parameters as follows: 150-200 give 4 units; 201-250 give 6 units; 251-300 give 8 units; 301-350 give 10 units; 351-400 give 12 units; 400 plus give 0 units and call doctor. -There was an order to check FSBS three times daily before meals. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 5:00pm. -There was an entry for Novolog sliding scale scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation Resident #2 refused FSBS checks 11 times from 10/01/21 through 10/31/21. -There was documentation Resident #2 refused Novolog sliding scale 13 times from 10/01/21 through 10/31/21. -There was no documentation the resident's PCP had been notified about the refusals. Review of Resident #2's November 2021 eMAR revealed: -There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 5:00pm. -There was an entry for Novolog sliding scale	C 246	basis for follow-up and referral and medication accuracy. Any resident who refuses a medication/treatment, the staff must notify the Administrator immediately. The Administrator will then attempt to administer the medication. After the third refusal the staff will notify the doctor immediately for guidance. Administrator will ensure medication compliance on a wklly basis.	12/14/21

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C 246	Continued From page 18 scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation FSBS checks were refused 13 times from 11/01/21 through 11/30/21. -There was documentation Novolog insulin was refused 8 times from 11/01/21 through 11/30/21. -There was no documentation the resident's PCP had been notified about the refusals. Review of Resident #2's "Resident Notes" for October and November 2021 revealed: -On 10/01/21 at 12:00pm, Resident #2 refused FSBS. -On 10/05/21 at 8:00am, Resident #2 refused morning medications, refused to get FSBS checked and refused insulin. At 12:00pm the resident refused FSBS checked and did not take insulin. At 5:00pm refused nighttime medications and FSBS. -On 10/06/21 at 8:00am, Resident #2 refused morning medications and refused FSBS. At 12:00pm he refused FSBS. At 5:00pm the resident refused nighttime medications. -On 10/07/21 at 8:00am, Resident #2 refused morning medications and FSBS. -On 10/09/21 at 8:00am, Resident #2 refused FSBS. -On 10/13/21 at 12:00pm, Resident #2 refused FSBS. -On 11/24/21, Resident #2 refused FSBS at 8:00am, 12:00pm and 5:00pm. -On 12/13/21 at 12:00pm, Resident #2 refused FSBS -There was no documentation in the notes the PCP was notified of the resident's refusals. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -Some days he refused FSBS and insulin because he did not feel well, he was tired, and sluggish with his head feeling like it was "in a	C 246		

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C 246	Continued From page 19 fog". -He was not aware if the PCP knew about his refusals. -He was unable to recall the last time he saw the PCP. -Sometimes he refused because the SIC/MA was not nice to him. -She yelled and cursed at him, so he did not want to be bothered with her. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/14/21 at 8:55am revealed: -Resident #2 frequently refused FSBS and insulin. -She had let the PCP know about the refusals. -She probably texted the PCP or called her; she could not remember what she did or when she contacted the PCP. -She was unable to provide text messages to show the PCP had been contacted. -She did not document that she had contacted the PCP, must have forgotten to document. -She was unable to recall the PCP's response to the resident refusing FSBS and insulin. -She did not know if the facility had a policy regarding refusal of medications. Telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm revealed: -The SIC/MA was responsible for letting the PCP know what was going on with the residents. -If a resident was refusing medications frequently, the PCP should be notified, and there should be documentation to show the PCP was notified. -There was no system in place to ensure the SIC/MA followed-up with the PCP regarding a resident's refusal of medications and treatments. -If the SIC/MA was not sure what to do, she should have contacted her or the House	C 246		

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C 246	Continued From page 20 Manager. -As of Today's date (12/14/21), the SIC/MA had not made her aware Resident #2 refused insulin and FSBS. Attempted telephone interview with Resident #2's PCP on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful.	C 246		
C 255	10A NCAC 13G .0903 (d) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (d) The facility shall assure action is taken in response to the licensed health professional review and documented, and that the physician or appropriate health professional is informed of the recommendations when necessary. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure follow-up to a recommendation made by the Licensed Health Professional Support Nurse (LHPS) for 2 of 3 sampled residents (Residents #1 and #2) related to notifying the physician regarding obtaining parameters for fingerstick blood sugar (FSBS) results (#1), and for a glycated hemoglobin test (A1C) and to clarify the sliding scale (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 07/15/21 revealed: -Diagnoses included type 2 diabetes.	C 255	Staff will review all LHPS at the time of retrieval. Any recommendations that are noted must be sent to the primary care doctor for review and further guidance. The Administrator will review all LHPS and follow up with recommendations on a quarterly basis.	12/16/21

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C 255	Continued From page 21 -There was an order to check fingerstick blood sugar (FSBS) once weekly. Review of Resident #1's Licensed Health Professional Support (LHPS) evaluation dated 10/14/21 revealed: -Resident #1 had an LHPS task for collecting and testing of fingerstick blood samples. -The LHPS nurse recommended obtaining parameters for FSBS results. Telephone interview with the LHPS nurse on 12/14/21 at 11:47am revealed: -She had written the recommendation for the Supervisor-In-Charge/medication aide (SIC/MA) to contact the primary care provider (PCP) to obtain parameters for FSBS results. -She thought that since the SIC/MA was not a Registered Nurse (RN), it would be beneficial for them to have parameters as to when to notify the PCP of FSBS that were too low or too high. -When she went to the facility to complete her LHPS evaluations, she reviewed all of the recommendations with the SIC/MA. Interview with the SIC/MA on 12/13/21 at 2:44pm revealed: -When the LHPS nurse was at the facility, she gave the completed evaluation forms to her; it was her responsibility as the SIC/MA to review the evaluations, complete the follow up recommendations, and place the evaluation form into the residents' records. -She had reviewed the LHPS evaluation for Resident #1 and saw there was a recommendation to obtain parameters for FSBS results. -She did not contact the PCP to request parameters for FSBS results; she had no explanation as to why.	C 255			

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C 255	Continued From page 22 Interview with the Acting Administrator on 12/14/21 at 11:25am revealed: -At the time of Resident #1's LHPS evaluation on 10/14/21, it had been the SIC/MA's responsibility to complete the recommendation follow-ups. -She was unaware the SIC/MA did not follow up on recommendations from the LHPS nurse. -She did not audit the records, and nobody had been assigned the responsibility of completing records audits. -It was her expectation that the SIC/MA should contact the PCP based on the LHPS nurse's recommendations, and document and implement the PCP's response. 2. Review of Resident #2's current FL2 dated 10/21/21 revealed diagnoses included diabetes. Review of Resident #2's LHPS review dated 10/14/21 revealed the nurse completing the review recommended to obtain an A1C (A test associated with diabetes) and to clarify the order for Novolog sliding scale. Review of Resident #2's physician's orders, resident notes and laboratory reports revealed: -There was no documentation the A1C was obtained or scheduled. -There was no documentation the Novolog sliding scale order had been clarified. Telephone interview with the LHPS nurse on 12/14/21 at 11:43am revealed: -She wrote a recommendation for the Supervisor-In-Charge/medication aide (SIC/MA) to contact the primary care provider (PCP) to obtain an A1C because the resident's FSSS were inconsistent on the eMAR. -She also recommended contacting the resident's	C 255		

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C 255	Continued From page 23 PCP to clarify the order for Novolog sliding scale because the SIC/MA told her the order for Novolog sliding scale on the eMAR was incorrect. -Before she left the facility, she went over the recommendations with the SIC/MA because she was not a Registered Nurse. -She wanted to make sure the SIC/MA had a clear understanding of the recommendations. Interview with the SIC/MA on 12/14/21 at 3:55am revealed: -When the LHPS nurse completed the quarterly reviews, she was responsible for reviewing the paperwork. -If the nurse made recommendations, she was responsible for following up with the recommendations with the appropriate entity. -She had not followed-up on the recommendations to obtain Resident #2's A1C or clarified the Novolog sliding scale. -She did think the Novolog order on the eMAR was incorrect, but she had not clarified the order with the PCP. -She had no explanation or reason why she had not followed-up with Resident #2's PCP. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -He was a diabetic, staff checked his FSBS and insulin was administered. -To his knowledge he had not been scheduled for a blood draw or laboratory test. -He had not been out of the facility or had blood drawn. Telephone interview with the Acting Administrator on 12/14/21 at 1:53pm revealed: -The SIC/MA was responsible for reviewing the LHPS reviews. -If the nurse completing the review made	C 255			

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C 255	Continued From page 24 recommendations, the SIC/MA was responsible for following-up on the recommendations as suggested. -The SIC/MA should document responses or progress to any recommendations made by the nurse. -She did not audit the records, and nobody had been assigned the responsibility of completing records audits.	C 255		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to offer or make snacks available to the residents three times a day. The findings are: Review of the facility's week-at-glance 7-day menu and therapeutic diet menus revealed: -A snack was listed on the regular menus at "HS" (bedtime) "snack of the day." -There was no food item listed for the snack. -Snacks were not listed on the therapeutic diet menus. Observation of the kitchen area and two food	C 272	12/14/21 Staff will provide appropriate snacks according to menus, three times daily. The Administrator will ensure the menus are accurate and the snacks are available.	

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C 272	Continued From page 25 storage closets on 12/13/21 at 9:05am revealed: -There were three apples in a bowl on top of the microwave. -There were no other food items that could be used for snacks. Observation of the residents on 12/13/21 at 11:00am revealed: -A resident asked the SIC/MA for a snack, the SIC/MA did not respond and left the room. -The resident murmured, "well, it was almost time for lunch." Observations in the facility on 12/13/21 between 8:20am to 4:45pm revealed no snacks were offered or made available to residents. Interview with a resident on 12/13/21 at 8:40am revealed: -He had a snack every day, three times per day because he had his own snacks. -He was not offered a snack every day by the facility staff. Interview with a second resident on 12/31/21 at 8:50am revealed when snacks were given, he got 2 snacks per day 2:00pm and 7:00pm. Interview with a third resident on 12/13/21 at 9:05am revealed: -Snacks were given once a week. -When he asked for a snack, he was told "we ain't got them." -The last time he was offered a snack was one week ago. -He would love a snack between meals. Interview with a fourth resident on 12/13/21 at 9:15am revealed: -Snacks were not offered three times daily.	C 272		

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NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 272	Continued From page 26 -He only got a snack if he brought them to the facility. Interview with a fifth resident on 12/13/21 at 9:20am revealed: -Sometimes snacks were offered "every row and then." -He purchased his own snacks and only got his snacks when he asked for them. Interview with the SIC/MA on 12/14/21 at 3:55am revealed: -Snacks were to be offered daily at 10:00am, 2:00pm and before bedtime. -She gave residents wafers, graham crackers, cheese-it crackers, fruit, cookies, and yogurt. -She kept snacks in another room of the facility. -When asked to see the snacks, the SIC/MA stated she did not have any of the mentioned food items on hand at the facility. -The menu did not list food items, so sometimes she made the residents peanut butter crackers. -She forgot to give out snacks yesterday on 12/13/21. Telephone interview with the Acting Administrator on 12/14/21 at 2:11pm revealed: -The House Manager brought perishable foods to the facility weekly. -She did grocery shopping every two weeks. -There should be foods for snacks at the facility. -If the SIC/MA did not have food items for snacks, she should have told her or the House Manager. -The House Manager was in the facility at least two times per week; there was no excuse why the SIC/MA did not tell her what she needed for the residents. -The SIC/MA had not called to inform her that food items were not available.	C 272		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PULLIAM FAMILY CARE HOME

**809 WEST MINNEOLA ROAD
GIBSONVILLE, NC 27249**

(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 274	Continued From page 27	C 274		
C 274	10A NCAC 13G .0904(d)(3)(B) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fruit was served twice daily to residents including a serving of citrus juice or fruit. The findings are: Observation of the refrigerator on 12/13/21 at 8:58am revealed there was no citrus juice or fruit juice available for serving to the residents. Review of the 7-day week-at-glance menu provided by the facility on 12/13/21 at 10:30am revealed fruit juice was to be served with the breakfast meal every day for the next seven days. Interview with a resident on 12/13/21 at 8:40am revealed: -He did not get fruit juice with the breakfast meal every morning. -He liked fruit juice and would like to have fruit	C 274	12/16/21 Staff will ensure that the menu is followed to be best ability and served accordingly. The Administrator will ensure the menus are accurate and the items are available on a wklly basis.	

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C 274	Continued From page 28 juice every day. -Currently, the facility was out of juice. -Last week they had fruit punch, but that was gone also. Interview with a second resident on 12/13/21 at 9:05am revealed: -No fruit juice was served for breakfast. -He would like to have fruit juice. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/13/21 at 9:50am revealed: -Every week food was brought to the house. -She did not have all the foods listed on the menu. -She served what she had. -The facility had not had fruit juice for over a week. -The Acting Administrator (AA) purchased food and the food was delivered to the facility by the House Manager. Interview with the AA on 12/14/21 at 2:11pm revealed: -The House Manager brought groceries to the facility every two weeks. -The House Manager brought foods like milk, eggs and bread to the facility weekly. -If there was a food item on the menu that was not in the facility and something else could not be substituted, the SIC/MA should contact her. -She visited the facility once monthly and had no idea of the foods needed at the facility. -She counted on the SIC/MA to keep track of the needed food items.	C 274		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service	C 284		

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C 284	Continued From page 29 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to serve therapeutic diets as ordered for 1 of 3 sampled residents (#3) with an order for chopped meats. The findings are: Review of Resident #3's current FL-2 dated 07/15/21 revealed: -Diagnoses included epilepsy and mild intellectual disability. -The diet order was not specified. Review of Resident #3's diet order dated 11/11/21 revealed an order for chopped meats. Observation of the kitchen on 12/13/21 at 12:00pm revealed there was no therapeutic diet list posted. Review of the 7-day week-at-a-glance menu for the lunch meal on 12/13/21 revealed residents were to be served rosemary chicken with wild rice, harvest beets, bread or roll, margarine, forest pairs, milk and beverage of choice. Review of the facility's therapeutic diet menus revealed there was no therapeutic diet menu for a chopped meats only diet.	C 284	Staff will ensure all residents are served diets that are ordered by the primary care doctor, no exceptions. Administrator will ensure proper diets are being served on a wklly basis.	12/16/21

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C 284	Continued From page 30 Observation of the lunch meal on 12/13/21 at 12:53pm revealed: -Resident #3 received one whole baked chicken leg, wild rice, cornbread, mixed vegetables, canned peaches, and soda. -He did not cough or display difficulty swallowing the chicken throughout the meal. -He consumed 100% of the meal including the chicken. Review of the 7-day week-at-a-glance menu for the lunch meal on 12/14/21 revealed residents were to be served veal fricassee, sour cream mashed potatoes, Scandinavian vegetable blend, wheat dinner roll or bread, margarine, fruited gelatin, milk and beverage of choice. Observation of the lunch meal on 12/14/21 at 12:57pm revealed: -Resident #3 received two whole hot dogs and a side of baked beans with water to drink. -He was observed swallowing slowly at times followed by taking a drink of water. -At 1:05pm, he coughed one time during the meal and the SIC/MA advised him to take a drink. Interview with Resident #3 on 12/14/21 at 9:34am revealed: -He was supposed to have chopped meats because he had difficulty swallowing since 2000. -He did not know why he had trouble swallowing, but he had a history of having a stroke. -The SIC/MA never chopped his meats; he always cut up his meat himself. -He wished the SIC/MA would provide chopped meats for him. -He had not asked the SIC for chopped meats. -He did not have difficulty swallowing the chicken leg that had been served to him at lunch the day prior; he usually had a hard time swallowing	C 284		

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C 284	Continued From page 31 meats that were more thick. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/13/21 at 2:44pm revealed: -She was not aware that Resident #3 was ordered a chopped meats diet. -Diet orders were in each resident's record. -Resident #3 generally did not have difficulty swallowing his meats, but at times if he was eating too fast, she would need to prompt him to take a drink to help him swallow certain foods. Interview with the acting Administrator on 12/14/21 at 11:36am revealed: -The SIC/MA was capable of providing Resident #3 with chopped meats. -It was her expectation that the SIC/MA familiarize herself with and follow diet orders as written by the primary care provider (PCP). -The SIC/MA was responsible for ensuring diet orders were followed. Attempted telephone interview with Resident #3's PCP on 12/14/21 at 8:42am was unsuccessful.	C 284		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131C-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 4	C 311	Staff are educated on residents rights upon hire, and re-educated on a monthly basis Administrator will ensure all residents rights are followed and adhered to on a weekly basis for two months, then monthly thereafter.	12/16/21

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C 311	Continued From page 32 sampled residents (Residents #2, #3 and #4) were treated with respect, dignity, and free of verbal abuse by Staff A who cursed and yelled at the residents. The findings are: Review of the facility's bulletin board in the main hallway revealed: -Residents Rights Policy (not dated) was posted. -The policy stated every resident had the right to be treated with respect, consideration, dignity, and be free of abuse. 1. Review of Resident #4's current FL2 dated 09/09/21 revealed diagnoses included schizophrenia, intellectual disability, hypertension, hyperlipidemia, Gastroesophageal reflux, obesity and diabetes type 2. -The resident was intermittently disoriented. Observations on of Staff A on 12/13/21 at 1:10pm revealed: -When standing outside the facility, 20 feet from the facility, Staff A could be heard loudly yelling at a resident. -It was identified Staff A was yelling at Resident #4. -Staff A said things like: "they don't want you, I keep telling you the same thing over and over," and lastly, she said "you need to learn to get along." -The resident was not heard saying anything. Interview with Resident #4 on 12/13/21 at 9:15am revealed: -He had resided at the facility for six months. -Staff A treated him differently than the other residents. -He wanted Staff A to be nice to him and talk with	C 311		

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C 311	Continued From page 33 him, but she would not. Interview with Staff A on 12/14/21 at 9:44am revealed: -Yesterday, two residents were arguing, and she intervened. -She did not intend to yell at Resident #4. -She was hard of hearing and sometimes she talked loudly. Interview with the Acting Administrator (AA) on 12/13/21 at 1:15pm revealed: -On two occasions she had conversations with Staff A regarding how she talked to the residents. -She had talked with Staff A to identify if she was overworked and Staff A said "she was fine", and she did not need time off work. -Staff A was not reported to the health care personnel registry because she did not think about reporting her. Refer to interview with the Acting Administrator (AA) on 12/13/21 at 1:23 pm. Refer to interview with Staff A on 12/14/21 at 9:40am. 2. Review of Resident #2's current FL2 dated 10/21/21 revealed diagnoses included diabetes, hypertension, schizoaffective disorder, and hypothyroidism. Review of Resident #2's October 2021 "Resident Notes" revealed: -On 10/24/21 (no time documented) early morning, Staff A, Supervisor-In-Charge/medication aide (S C/MA) told the resident not to go outside because it was still dark outside. -The resident said to the Staff A, "you're crazy."	C 311		

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C 311	Continued From page 34 -The Staff A responded back to the resident, "no you are crazy." Interview with Resident #2 on 12/14/21 at 10:55am revealed: -Staff A was not nice to him. -In the mornings she woke him up between 6:30 and 7:00am to take medications. -When Staff A woke him up, she yelled at him and she cursed at him. -When Staff A cursed, she said words like "[expletive] and [expletive]" in sentences related to him. -When Staff A cursed, it made him upset that she yelled and cursed at him. -He had told the Acting Administrator (AA) about Staff A yelling and cursing at him, but nothing was done. -Staff A continued to yell and curse at him Telephone interview with Resident #2's guardian on 12/14/21 at 9:03am revealed: -In October 2021, she was informed by Resident #2 that the Staff A yelled and cursed at him. -She talked with the AA about Staff A yelling and cursing at Resident #2. -The AA stated she would talk with Staff A. Interview with the AA on 12/13/21 at 1:15pm revealed: -Twice, she physically came to the facility to have a conversation with Staff A because the residents complained to her that Staff A yelled and cursed at them. -Each time she talked with Staff A and told her to treat residents with respect. -She had Staff A complete residents' rights training at the end of October 2021. Refer to interview with the Acting Administrator	C 311		

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C 311	Continued From page 35 (AA) on 12/13/21 at 1:23 pm. Refer to interview with Staff A on 12/14/21 at 9:40am. 3. Review of Resident #3's current FL-2 dated 07/15/21 revealed diagnoses included schizophrenia and mild intellectual disability. Observations on of Staff A on 12/13/21 at 1:10pm revealed: -When standing outside the facility, 20 feet from the facility, Staff A could be heard loudly yelling at a resident. -Staff A said things like: "they don't want you, I keep telling you the same thing over and over," and lastly, she said "you need to learn to get along." -The resident was not heard saying anything. Interview with Resident #3 on 12/14/21 at 9:34am revealed: -Staff A yelled at him almost every morning. -In the morning, he liked to take his coffee outside and drink it while sitting on the porch. -She yelled at him and told him he had to drink the coffee at the kitchen table, not sitting on the front porch. -Most of the time when he was being yelled at it was because he was moving too slow to go and do what she wanted him to do such as get in the shower. -He moved slow because he had a stroke. -Staff A would say things such as "get your [expletive] up" or "get your [expletive] in the shower." -It bothered him to be yelled at and it made him feel like he was not wanted at the facility. -He did not remember Staff A yelling the day prior (12/13/21) after lunch.	C 311		

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C 311	Continued From page 36 -He wished there would be a different SIC/MA who did not cuss at the residents. Refer to interview with the Acting Administrator on 12/13/21 at 1:23 pm. Refer to interview with Staff A on 12/14/21 at 9:40am. Interview with the AA on 12/13/21 at 1:23pm revealed: -Twice, she physically came to the facility to have a conversation with Staff A because the residents complained to her that Staff A yelled and cursed at them. -Each time she talked with Staff A and told her to treat residents with respect. -She had Staff A complete residents' rights training at the end of October 2021. -She had not followed-up with the residents to see if Staff A continued to yell and curse at them. Interview with Staff A on 12/14/21 at 9:40am revealed: -She did not treat residents mean, yell or curse at them. -She was hard of hearing and sometimes when she talked her voice sounded loud. -She was good to the residents and treated them how she wanted to be treated. The facility failed to ensure residents were treated with respect and dignity related to the Staff A observed loudly yelling at a resident with a diagnosis of mental disorders resulting in the resident becoming upset (#4); another resident reported Staff A yelled and cursed at them (#2); Staff A yelling and cursing at a third resident making the resident feel he was not wanted (#3). This failure was detrimental to the health safety,	C 311		

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C 311	Continued From page 37 and welfare of the residents which constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2022.	C 311			
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to contact the primary care provider for clarification of medication orders for 2 of 3 sampled residents (Residents #1 and #2) related to sliding scale insulin without parameters, pain/fever medication that was enteric-coated or chewable (#2), and an	C 315	12/16/21 Staff will review all new medication orders with current medication orders and contact the primary care doctor for any clarification needed immediately. The Administrator will ensure all medication orders are accurate and current on a weekly basis.		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PULLIAM FAMILY CARE HOME

**809 WEST MINNEOLA ROAD
GIBSONVILLE, NC 27249**

(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 315	Continued From page 38 N-methyl-D-aspartate receptor antagonist (#1). The findings are: 1. Review of Resident #2's current hospital FL2 dated 10/21/21 revealed: -Diagnoses included diabetes, hypertension, schizoaffective disorder, hypothyroidism and community-acquired pneumonia. a. Review of Resident #2's current hospital FL2 dated 10/21/21 revealed: -There was an order for Novolog 0-12 units three times daily with meals (fast-acting insulin used to control diabetes). -There was no order for finger stick blood sugars (FSBS) on the FL2 dated 10/21/21. Review of Resident #2's previous physician's order sheet dated 07/30/21 revealed: -There was an order for Novolog sliding scale insulin (SSI) with parameters as follows: 150-200 give 4 units; 201-250 give 6 units; 251-300 give 8 units; 301-350 give 10 units; 351-400 give 12 units; 400 plus give 0 units and call doctor. -There was an order to check FSBS three times daily before meals. Review of Resident #2's physician's orders revealed there was no orders after 10/21/21 for Novolog SSI with parameters and FSBS. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was no entry for Novolog 0-12 units three times daily with meals on the eMAR. -There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 5:00pm. -There was an entry for Novolog sliding scale with	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
(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 315	Continued From page 39 parameters as follows: 150-200 give 4 units; 201-250 give 6 units; 251-300 give 8 units; 301-350 give 10 units; 351-400 give 12 units; 400 plus give 0 units and call doctor and scheduled at 8:00am, 12:00pm and 5:00pm. Review of Resident #2's November 2021 eMAR revealed: -There was no entry for Novolog 0-12 units three times daily with meals on the eMAR. -There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 5:00pm. -There was an entry for Novolog sliding scale with parameters as follows: 150-200 give 4 units; 201-250 give 6 units; 251-300 give 8 units; 301-350 give 10 units; 351-400 give 12 units; 400 plus give 0 units and call doctor and scheduled at 8:00am, 12:00pm and 5:00pm. Review of Resident #2's December 2021 eMAR revealed: -There was no entry for Novolog 0-12 units three times daily with meals on the eMAR. -There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 5:00pm. -There was an entry for Novolog sliding scale with parameters as follows: 150-200 give 4 units; 201-250 give 6 units; 251-300 give 8 units; 301-350 give 10 units; 351-400 give 12 units; 400 plus give 0 units and call doctor and scheduled at 8:00am, 12:00pm and 5:00pm. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -He was a diabetic and received insulin. -He did not know the name of insulin ordered and he did not know if he was ordered insulin with a sliding scale. -Most days his FSBS was checked three times per day, but not every day.	C 315		

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C 315	Continued From page 40 -Sometimes he received an injection of insulin but not that often. -The Supervisor-In-Charge/medication aide (SIC/MA) took care of his medications. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 8:47am revealed: -The last order the pharmacy had for Resident #2's Novolog and FSBS was dated 07/30/21. -The pharmacy had not received the current FL2 dated 10/21/21. -When the pharmacy received a new or changed order they compared the order with previous orders on the eMARs. -If an order was received that was incomplete or not clear the pharmacist contacted the doctor to clarify the order. Interview with the SIC/MA on 12/13/21 at 2:40pm revealed: -She checked Resident #2's FSBS three times daily, if he allowed her to. -Resident #2 was supposed to receive insulin when his FSBS was 150 or above based on the order printed on eMAR by the pharmacy. -If there was another order she was not aware of the order. -When a resident returned from a hospital visit she was responsible for checking the paperwork and faxing the orders to the pharmacy. -She was to compare new orders with the eMARs. -If there were incomplete orders or she did not understand an order she was supposed to contact the doctor. -She had not seen Resident #2's current hospital FL2 dated 10/21/21 because she never looked at the hospital discharge paperwork. -She had no reason why she did not review	C 315		

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C 315	Continued From page 41 Resident #2's hospital discharge paperwork, but thought she must have forgotten about the paperwork. Telephone interview with the AA on 12/14/21 at 11:12am revealed: -She took over the operations of the facility in July 2021. -When she took over the operations of the facility the SIC/MA was already employed at the facility. -She did not have a system in place to ensure medication orders were checked for clarification. -The SIC/MA was responsible for reviewing all paperwork when a resident returned from the hospital. -The MA was supposed to compare orders on the new paperwork with the eMARs to identify any new or changed medications. -If the SIC/MA did not clearly understand medication orders or the orders were incomplete, the SIC/MA was supposed to contact the doctor at the hospital. -If the SIC/MA was unable to communicate with the doctor at the hospital, then she was supposed to contact the resident's primary care provider (PCP) to clarify the orders. -The SIC/MA was supposed to send any orders received to the pharmacy. -If there was an incomplete order, then the pharmacy would contact the doctor to clarify the order before entering the order on the eMARs. -The HM was at the facility two to three days per week and would have assisted the SIC/MA. -If the HM was unable to assist the SIC/MA, the HM would have let her know the SIC/MA needed help. -She talked with the SIC/MA several times per month and asked how things were going. Attempted telephone interviews with Resident	C 315		

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C 315	Continued From page 42 #2's PCP on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. Refer to second telephone interview with the AA on 12/14/21 at 4:53pm. b. Review of Resident #2's current hospital FL2 dated 10/21/21 revealed an order for aspirin 81mg enteric-coated (EC) (used to treat fever and mild pain) daily, swallow whole. Review of Resident #2's physician's order sheet dated 11/11/21 revealed an order for aspirin 81mg chewable daily. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was no entry for aspirin 81mg EC daily, swallow whole on the eMAR. -There was an entry for aspirin 81mg chewable scheduled for administration at 8:00am. -There was documentation aspirin chewable was administered daily at 8:00am from 10/01/21 through 10/31/21. Review of Resident #2's November 2021 eMAR revealed: -There was no entry for aspirin 81mg EC daily, swallow whole on the eMAR. -There was an entry for aspirin 81mg chewable scheduled for administration at 8:00am. -There was documentation aspirin chewable was administered daily at 8:00am from 11/01/21 through 11/30/21. Review of Resident #2's progress notes and	C 315			

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C 315	Continued From page 43 primary care provider (PCP) communication sheets revealed there was no documentation the resident's PCP had been contacted to clarify the order for aspirin 81mg chewable and aspirin 81mg EC swallow whole. Observation of Resident #2's medications on hand at the facility on 12/13/21 at 11:35am revealed: -Aspirin 81mg chewable was available for administration. -The bubble packed container was filled and dispensed on 12/01/21 for a quantity of 30 tablets. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -He was administered medications daily but he did not know the names of the medications administered. -He did not know the difference between aspirin EC and chewable. -He did not remember chewing any of his medications. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 1:33pm revealed: -The pharmacy did not have an order for aspirin 81mg EC for Resident #2. -The pharmacy had not received the FL2 dated 10/21/21. -The pharmacy had the physician's order dated 11/11/21. -The order for aspirin 81mg EC verses chewable should be clarified. -The aspirin EC helped with digestion and could prevent less stomach irritation. Interview with the	C 315		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PULLIAM FAMILY CARE HOME

809 WEST MINNEOLA ROAD

GIBSONVILLE, NC 27249

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C 315	Continued From page 44 Supervisor-In-Charge/medication aide (SIC/MA) on 12/14/21 at 8:55am revealed: -She had not reviewed Resident #2's FL2 dated 10/21/21. -She did not realize the resident's order for aspirin 81mg enteric coated had changed to chewable. -She did not know what enteric-coated meant. -If she had seen the order, she would not have known to clarify the order. -She was responsible for reviewing all the paperwork for residents at the facility. -If she did not understand the instructions on an order, she was supposed to contact the physician who wrote the order to clarify the order. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. Refer to second telephone interview with the AA on 12/14/21 at 4:53pm. 2. Review of Resident #1's current FL2 dated 07/15/21 revealed: -Diagnoses included type 2 diabetes, bipolar depression and stage 3 chronic kidney disease. -There was an order for memantine (used to treat memory loss) 10mg take a half tablet every day. Review of Resident #1's signed physician's order sheet dated 11/11/21 revealed memantine 10 mg was not listed on the physician's order sheet as an active order. Review of Resident #1's October, November and December 2021 electronic medication administration record (eMAR) revealed there was no entry for memantine 10mg take a half tablet every day. Observation of Resident #1's medications on	C 315		

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C 315	Continued From page 45 hand on 12/13/21 at 10:00am revealed there was a bottle labeled for memantine 10mg take one half tablet every day with a dispensed date of 12/02/21 with an undetermined number of tablets left in the bottle. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/13/21 at 2:44pm revealed: -She was the primary SIC/MA at the facility; she had worked every day since mid-October 2021 and was familiar with Resident #1's medications. -She did not know why memantine was not listed on Resident #1's eMARs. -The resident had been receiving memantine since she started working in June 2021 and she signed it off on his eMAR daily after administering it. -As far as she knew the memantine order had never been discontinued. Telephone interview with the Acting Administrator (AA) on 12/14/21 at 4:55pm revealed: -She was not aware of Resident #1's memantine order being discontinued or why it would be dispensed from the pharmacy but not active on the eMAR. -It was her expectation if there was a medication on hand that did not match the eMAR or the most recently signed physician order sheet, the SIC/MA should call the PCP for clarification or verification that the order was still active. - All communication with the PCP needed to be documented with the date, time, and caller's initials. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. Refer to second telephone interview with the AA	C 315		

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C 315	Continued From page 46 on 12/14/21 at 4:53pm. Telephone interview with the AA on 12/14 21 at 1:53pm revealed: -When a resident had a doctor visit the SIC/MA was responsible for reviewing the paperwork. -The SIC/MA was supposed to compare the medication orders received with the current eMARs to identify new, changed or discontinued medications. -There was no system in place for checking behind the SIC/MA to ensure incoming orders were reviewed and compared with the medication on the current eMARs to verify accuracy. Second telephone interview with the AA on 12/14/21 at 4:53pm revealed: -If orders received were not clear or the SIC/MA was not sure how to administer a medication, then the SIC/MA was supposed to contact the physician who wrote the order to clarify the order. -If the SIC/MA was unable to communicate with the physician who wrote it, then she was to contact the resident's PCP, provided the physician who wrote the order was not the PCP. -If the SIC/MA had difficulty getting in touch with the PCP, the SIC/MA should contact her to let her know what was happening.	C 315		
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	C 330	All medications will be administered by the staff as ordered by the doctors. Administrator will ensure all meds are given accurately and appropriately on a weekly basis.	12/16/21

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C 330	Continued From page 47 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, record reviews and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (Residents #1, #2, and #3) related to insulin administration, an antibiotic, an expectorant, multi-vitamins and administered discontinued medications for blood pressure and a potassium supplement (#2), a resident not administered a receptor antagonist medication (#1), and a resident not administered an anti-anxiety medication and an anti-depressant medication (#3). The findings are: 1. Review of Resident #2's current hospital FL2 dated 10/21/21 revealed: -Diagnoses included diabetes, hypertension, schizoaffective disorder, hypothyroidism and community-acquired pneumonia. -There was no order for finger stick blood sugars (FSBS) on the FL2. a. Review of Resident #2's current hospital FL2 dated 10/21/21 revealed there was an order for Novolog 0-12 units three times daily with meals (fast-acting insulin used to control diabetes). Review of Resident #2's previous physician's order sheet dated 07/30/21 revealed: -There was an order for Novolog sliding scale insulin (SSI) with parameters as follows: 150-200	C 330		

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C 330	Continued From page 48 give 4 units; 201-250 give 6 units; 251-300 give 8 units; 301-350 give 10 units; 351-400 give 12 units; 400 plus give 0 units and call doctor -There was an order to check FSBS three times daily before meals. Review of Resident #2's physician's orders revealed there was no current order for Novolog SSI with parameters. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was no entry for Novolog 0-12 units three times daily with meals on the eMAR. -There was an entry for FSBS three times daily scheduled at 8:00am, 12:00pm and 5:00pm. -There was an entry for Novolog sliding scale with parameters, the site, FSBS and units of insulin given scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation FSBS were obtained 31 out of 63 opportunities from 10/01/21 through 10/21/21. -There was documentation FSBS obtained were within range for Novolog sliding scale insulin 11 out of 31 FSBS obtained. -There was documentation Novolog was administered incorrectly 9 times with examples as follows: -On 10/02/21 at 12:00pm, FSBS was 160, 6 units was documented as administered, and should have administered 4 units. -On 10/02/21 at 5:00pm, FSBS was 195, 0 units was documented as administered, and should have administered 4 units. -On 10/03/21 at 12:00pm, FSBS was 167, 6 units was documented as administered, and should have administered 4 units. -On 10/04/21 at 12:00pm, FSBS was 183, 6 units	C 330		

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PULLIAM FAMILY CARE HOME

**809 WEST MINNEOLA ROAD
GIBSONVILLE, NC 27249**

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C 330	Continued From page 49 was documented as administered, and should have administered 4 units. -On 10/08/21 at 12:00pm, FSBS was 178, 6 units was documented as administered, and should have administered 4 units. -On 10/09/21 at 12:00pm, FSBS was 171, 6 units was documented as administered, and should have received 4 units. -On 10/11/21 at 12:00pm, FSBS was 237, 8 units was documented as administered, and should have administered 6 units. -On 10/12/21 at 12:00pm, FSBS was 159, 6 units was documented as administered, and should have administered 4 units. -FSBS ranged between 67 and 237 from 10/01/21 through 10/31/21. Observation of Resident #2's medications on hand at the facility on 12/13/21 at 11:35am revealed Novolog was available for administration. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -He was a diabetic and received insulin. -He did not know the name of insulin ordered and he did not know if he was ordered insulin with a sliding scale. -Most days his FSBS was checked three times per day, but not every day. -Sometimes he received an injection of insulin but not that often. -The Supervisor-In-Charge/medication aide (SIC/MA) took care of his medications. Interview with the SIC/MA on 12/13/21 at 2:40pm revealed: -She checked Resident #2's FSBS three times daily, if he allowed her to. -Resident #2 was supposed to receive insulin	C 330		

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C 330	Continued From page 50 when his FSBS was 150 or above based on the order printed on eMAR by the pharmacy. -If there was another order she was not aware of the order. -She had not seen the FL2 dated 10/21/21 because she never looked at the hospital discharge paperwork. -She was unable to explain why in October 2021, she administered Novolog incorrectly. -She thought maybe she was not wearing her glasses, or she accidentally entered the wrong amount of insulin on the eMAR. -She did not know how to document the units of insulin administered on the eMAR. -She had problems trying to figure out how the eMAR system worked. -She had not told the Acting Administrator (AA) or the House Manager (HM) that she had difficulties using the eMAR system. Telephone interview with the AA on 12/14/21 at 11:12am revealed: -She took over the operations of the facility in July 2021. -When she took over the operations of the facility, the SIC/MA was already employed at the facility. -She changed the facility's contracted pharmacy to a pharmacy that offered the eMAR system in July 2021. -When she switched to the new pharmacy, she provided training to the SIC/MA on how to use the eMAR system. -She did not have a system in place to review the eMARs to ensure medications were administered as ordered. -The SIC/MA was aware when she administered medications she should document to show medications were administered as ordered. -If the SIC/MA was not sure where to document the amount of insulin administered on the eMAR,	C 330		

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NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 330	Continued From page 51 the SIC/MA should have asked her or the HM. -The HM was at the facility two to three days per week and would have assisted the SIC/MA. -If the HM was unable to assist the SIC/MA, the HM would have let her know the SIC/MA needed help. -She talked with the SIC/MA several times per month and asked how things were going. -The SIC/MA never told her that she had difficulty with the eMAR system. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful. Refer to interview with the House Manager (HM) on 12/14/21 at 4:20pm. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. b. Review of Resident #2's current hospital FL2 dated 10/21/21 revealed an order for levofloxacin 750mg daily for three days (used to treat community-acquired pneumonia) to start on 10/22/21. Review of Resident #2's hospital discharge summary report that was attached to the FL2 dated 10/21/21 revealed: -A note was printed at the bottom of the report to "pick up these medications at the named pharmacy and address." -Levofloxacin was listed as one of the medications to pick-up. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed there was no entry for levofloxacin	C 330		

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NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 330	Continued From page 52 750mg on the eMAR. Observation of Resident #2's medications on hand at the facility on 12/13/21 at 11:35am revealed levofloxacin was not available for administration. Telephone interview with a representative at the hospital's pharmacy listed on the hospital discharge summary report on 12/14/21 at 1:33pm revealed: -Resident #2's medications all year had never been picked-up. -No one had called to inquire about the medications. -The pharmacy reached out to staff at the facility, but had no success. -If medications were not picked-up within one week they were returned to stock. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -In October 2021, he went to the hospital because he was not feeling well. -He was diagnosed with pneumonia. -He returned to the facility but was not aware if he was ordered a new medication. -He did not know the names of his medications and he did not know the dosages ordered, but he would know if a new medication was added. -He was not administered an antibiotic when he returned to the facility after a hospital admission in October 2021. -Some days he still did not feel well and he sometimes had a cough that was annoying. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 8:47am revealed: -The pharmacy did not have Resident #2's	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 330	Continued From page 53 current FL2 dated 10/21/21. -The pharmacy had not received an order for levofloxacin 750mg. -The pharmacy had never filled or dispensed levofloxacin for Resident #2. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/14/21 at 8:55am revealed: -She received Resident #2's FL2 when he returned from the hospital and back to the facility on 10/21/21. -She did not send the FL2 to the pharmacy because she did not look at the hospital discharge paperwork. -She did not read the FL2 or compare the orders on the FL2 with the eMARs to identify if there were any new, changed or discontinued medications. -As the SIC/MA, it was her responsibility to review paperwork, but she did not review Resident #2's hospital discharge paperwork. -She had no reason why she did not review the FL2 or the discharge paperwork. -She did not administer an antibiotic to Resident #2 in October 2021. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful. Refer to interview with the House Manager (HM) on 12/14/21 at 4:20pm. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. c. Review of Resident #2's current hospital FL dated 10/21/21 revealed an order to discontinue	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 330	Continued From page 54 metoprolol 25mg take ½ tablet (12.5mg) every daily (used to treat high blood pressure). Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for metoprolol 25mg take ½ tablet (12.5mg) in the morning. -There was documentation metoprolol was administered daily from 10/21/21 through 10/31/21. Review of Resident #2's November 2021 eMAR revealed: -There was an entry for metoprolol 25mg take ½ tablet (12.5mg) in the morning. -There was documentation metoprolol was administered daily from 11/01/21 through 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for metoprolol 25mg take ½ tablet (12.5mg) in the morning. -There was documentation metoprolol was administered daily from 12/01/21 through 12/13/21. Observation of Resident #2's medications on hand at the facility on 12/13/21 at 11:35am revealed: -There were two cards of metoprolol 25mg ½ tablet (12.5mg) was available for administration. -One card was filled and dispensed on 12/04/21 for a 30 day supply with 1 tablet remaining. -There was a full card of metoprolol 25mg 1/2 tablet with a dispensing date of 12/02/21 with 30 tablets remaining. Interview with Resident #2 on 12/14/21 at 8:55am	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 330	Continued From page 55 revealed: -He was administered medications at least twice daily. -He did not know the names of his medications, but he did not think any of his medications had been stopped. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 8:47am revealed: -The pharmacy did not have a discontinuation order for metoprolol. -The pharmacy had not received Resident #2's FL2 dated 10/21/21. -Metoprolol was cycle filled and dispensed monthly to the facility. -Metoprolol was last filled and dispensed on 12/02/21 for a 30 day supply. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/14/21 at 8:55am revealed: -She did not realize metoprolol had been discontinued. -She was responsible for reviewing paperwork when a resident returned from a hospital visit. -She had no reason why she had not reviewed Resident #2's hospital discharge FL2 dated 10/21/21. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful. Refer to interview with the House Manager (HM) on 12/14/21 at 4:20pm. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 330	Continued From page 56 d. Review of Resident #2's current FL2 dated 10/21/21 revealed an order to discontinue potassium chloride 20mEq twice daily (used to treat a potassium deficiency). Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for potassium chloride 20mEq twice daily schedule for administration at 8:00am and 8:00pm. -There was documentation potassium chloride was administered twice daily at 8:00am and 8:00pm from 10/21/21 through 10/31/21. Review of Resident #2's November 2021 electronic medication administration record (eMAR) revealed: -There was an entry for potassium chloride 20mEq twice daily schedule for administration at 8:00am and 8:00pm. -There was documentation potassium chloride was administered twice daily at 8:00am and 8:00pm from 11/01/21 through 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for potassium chloride 20mEq twice daily schedule for administration at 8:00am and 8:00pm. -There was documentation potassium chloride was administered twice daily at 8:00am and 8:00pm from 12/01/21 through 11/13/21. Observation of Resident #2's medications on hand at the facility on 12/13/21 at 11:35am revealed: -There were three bubble cards of potassium chloride 20mEq was available for administration.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 330	Continued From page 57 -One was dispensed on 11/04/21, there were 12 dosages remaining. -The other two bubble cards were unopened with 60 tablets remaining. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -He was administered medications at least twice daily. -He knew what his medications looked like, but he did not know the names of his medications. -He did not know if potassium chloride was administered to him. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 8:47am revealed: -The pharmacy did not have a discontinuation order for potassium chloride. -The pharmacy cycle filled and dispensed potassium chloride monthly since July 2021. Interview with the Supervisor-In-Charge/medication aide (SIGMA) on 12/14/21 at 8:55am revealed: -She administered potassium chloride to Resident #2 twice daily. -She was responsible for reviewing paperwork when a resident returned from a hospital visit. -She did not know Resident #2 had orders to discontinue potassium chloride. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful. Refer to interview with the House Manager (HM) on 12/14/21 at 4:20pm.	C 330		

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C 330	Continued From page 58 Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. e. Review Resident #2's current hospital FL2 dated 10/21/21 revealed an order for mucir-ex 600mg twice daily (used to relieve chest congestion). Review of Resident #2's hospital discharge summary report attached to the FL2 dated 10/21/21 revealed: -A note was printed at the bottom of the report to "pick up these medications at the named pharmacy and address." -Mucinex was listed as one of the medications to pick-up. Review of Resident #2's October, November and December 2021 electronic medication administration record (eMAR) revealed there was no entry for mucinex on the eMAR. Observation of Resident #2's medications on hand on 12/13/21 at 11:35am revealed mucinex was not available for administration. Telephone interview with a representative at the hospital's pharmacy listed on the hospital discharge summary report on 12/14/21 at 1:33pm revealed: -No one had called to inquire about Resident #2's medications. -The pharmacy did not fill the order for mucinex and did not attempt to contact anyone regarding this medication because the medication could be purchased over the counter. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -He previously had pneumonia and went to the	C 330		

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C 330	Continued From page 59 hospital in October 2021. -He had not received any new medications since he returned to the facility from the hospital. -He was not administered mucinex. -He was better than he was in October 2021, but some days he still did not feel well. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 8:47am revealed: -The pharmacy did not have Resident #2's current FL2 dated 10/21/21. -The pharmacy had not received an order for mucinex for Resident #2. -The pharmacy had never filled or dispensed mucinex for Resident #2. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/14/21 at 8:55am revealed: -She received Resident #2's FL2 when he returned back the facility on 10/21/21. -She did not know there was an order for mucinex 600mg on the FL2. -She was supposed to review the medications on the FL2, but she did not. -She had no reason why she did not review the FL2. -She had not administered mucinex to Resident #2. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful. Refer to interview with the House Manager (HM) on 12/14/21 at 4:20pm. Refer to telephone interview with the Acting	C 330		

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C 330	Continued From page 60 Administrator (AA) on 12/14/21 at 1:53pm. f. Review of Resident #2's current hospital F.L2 dated 10/21/21 revealed an order for multi-vitamin once daily (used to treat vitamin deficiencies). Review of Resident #2's hospital discharge summary report that was attached to the F.L2 dated 10/21/21 revealed: -A note was printed at the bottom of the report to "pick up these medications at the named pharmacy and address." -Multi-vitamin was listed as one of the medications to pick-up. Review of Resident #2's October, November, and December 2021 electronic medication administration record (eMAR) revealed there was no entry for multi-vitamin on the eMAR. Observation of Resident #2's medications on hand at the facility on 12/13/21 at 11:35am revealed multi-vitamin was not available for administration. Telephone interview with a representative at the hospital's pharmacy listed on the hospital discharge summary report on 12/14/21 at 1:33pm revealed: -No one had called to inquire about Resident #2's medications. -The pharmacy did not fill the order for multi-vitamin and did not attempt to contact anyone about the vitamin because the medication could be purchased over the counter. Interview with Resident #2 on 12/14/21 at 10:45am revealed: -He did not know the names and dosages of his	C 330		

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C 330	Continued From page 61 medications but if a new medication was added he was able to identify it was different. -He had not received any new medications since he returned to the facility from the hospital in October 2021. -He was not administered a multi-vitamin. -He would like a multi-vitamin if it would help him feel better. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 8:47am revealed: -The pharmacy did not have Resident #2's current FL2 dated 10/21/21. -The pharmacy had not received an order for multi-vitamin for Resident #2. -The pharmacy had never filled or dispensed multi-vitamin for Resident #2. Interview with the Supervisor-In-Charge/medication aide (S/C/MA) on 12/14/21 at 8:55am revealed: -Resident #2 was not currently administered a multi-vitamin. -She had not reviewed the FL2 dated 10/21/21 and did not know there was an order for a multi-vitamin. Attempted telephone interviews with Resident #2's primary care provider (PCP) on 12/14/21 at 8:41am, 9:41am, 1:51pm and 4:19pm were unsuccessful. Refer to interview with the House Manager (HM) on 12/14/21 at 4:20pm. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. 2. Review of Resident #1's current FL2 dated	C 330		

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C 330	Continued From page 62 07/15/21 revealed: -Diagnoses included Type 2 diabetes, bipolar depression and stage 3 chronic kidney disease. -There was an order for memantine (used to treat memory loss) 10mg take a half tablet every day. Review of Resident #1's signed physician's order sheet dated 11/11/21 revealed memantine 10 mg was not listed on the physician's order sheet as an active order. Review of Resident #1's October, November and December 2021 electronic medication administration record (eMAR) revealed there was no entry for memantine 10mg take a half tablet every day. Observation of Resident #1's medications on hand on 12/13/21 at 10:00am revealed there was a bottle labeled for memantine 10mg take one half tablet every day with a dispensed date of 12/02/21 with an undetermined number of tablets left in the bottle. Interview with the Supervisor-In-Charge/Medication Aide (SIC/MA) on 12/13/21 at 2:44pm revealed: -She was the primary SIC/MA at the facility; she had worked every day since mid-October 2021 and was familiar with Resident #1's medications. -She did not know why memantine was not listed on Resident #1's eMARs. -The resident had been receiving memantine since she started working there in June 2021 and she thought she signed it off on his eMAR daily after administering it. -As far as she knew the memantine order had never been discontinued. Interview with the Acting Administrator on	C 330		

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C 330	Continued From page 63 12/14/21 at 4:55pm revealed: -She was not aware of Resident #1's merr-antine order being discontinued or why it would be dispensed from the pharmacy but not active on the eMAR. -It was her expectation that all medications be administered as ordered and documented afterward. Attempted telephone interview with Resident #1's primary care provider (PCP) on 12/14/21 at 9:02am was unsuccessful. Refer to interviews with the House Manager (HM) on 12/13/21 at 4:20pm. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. 3. Review of Resident #3's current FL-2 dated 07/15/21 revealed diagnoses included schizophrenia and mild intellectual disability. a. Review of Resident #3's physician's order dated 11/05/21 revealed there was an order to change lorazepam from 1mg three times a day to 0.5mg three times a day. Review of Resident #3's subsequent physician orders dated 11/11/21 revealed there was an order for lorazepam 0.5mg take one tablet three times daily. Review of Resident #3's November 2021 eMAR revealed: -There was an entry for lorazepam 1mg take 1 tablet three times daily with a discontinue date of 11/05/21. -There was documentation lorazepam 1mg was administered three times daily at 8:00am 2:00pm	C 330		

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NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 330	Continued From page 64 and 8:00pm from 11/01/21 through the 8:00am administration on 11/04/21. -There was no documentation lorazepam 1mg was administered at 2:00pm or 8:00pm on 11/04/21. -There was no documented reason why lorazepam 1 mg was not administered. -There was an entry for lorazepam 0.5mg take 1 tablet three times daily with a start date of 11/06/21. -There was documentation lorazepam 0.5 ng was administered three times daily at 8:00am, 2:00pm and 8:00pm from 11/13/21 through 11/30/21. -There was no documentation lorazepam 0.5mg was administered 11/06/21 through 11/12/21 with no documented reason why lorazepam 0.5mg was not administered. Observation of medications on hand for Resident #3 on 12/13/21 at 10:00am revealed: -There was a medication bubble pack for lorazepam 0.5mg take 1 tablet three times daily and dispensed on 12/06/21 with a quantity of 90 tablets and there were 75 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 10:30am revealed: -They had an order on file for lorazepam 0.5mg take one tablet three times daily for Resident #3. -The order started on 11/05/21 and prior to that the order was for lorazepam 1mg take one tablet three times daily (which started 07/27/21 when their pharmacy took over dispensing medications for this facility). -The pharmacy last dispensed lorazepam 0.5mg on 11/05/21 with a quantity of 90 tablets which was a 30-day supply, and on 12/06/21 with a quantity of 90 tablets. -When the pharmacy received a new medication	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 330	Continued From page 65 order, it was either faxed to them by the prescriber or the facility, or an electronic prescription was sent by the provider. -The pharmacy would then enter the order on the eMAR and the facility would need to verify the order for the order entry to become active on the eMAR. Interview with the SIC/MA on 12/13/21 at 2:44pm revealed: -She never missed giving Resident #3 any of his doses of medication. -She did not know why there was missing documentation on the eMAR for lorazepam from 11/04/21 through 11/12/21. She thought she documented administering medication during that time and the documentation just was not showing up on the eMAR. -There was no process in place for other staff to audit the eMAR and check her documentation and she did not complete audits either; she did not know who was responsible for completing audits. Interview with Resident #3 on 12/14/21 at 9:34am revealed: -He did not know if he was administered lorazepam. -He received medications every day but was not sure what lorazepam was or what lorazepam looked like. -He did not know if he ever missed doses of medications because he did not count his pills when they were given to him. Interview with the Acting Administrator on 12/14/21 at 11:25am revealed: -She was not aware of Resident #3 missing documentation of medication administration for lorazepam.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 330	Continued From page 66 -The MA should not be administering any medication unless it was entered on the eMAR and matched the physician's order. -The MA should be checking each medication against the eMAR during the medication pass and documenting the administration as soon as Resident #3 took his medication. Attempted telephone interview with Resident #3's current PCP on 10/14/21 at 8:42am was unsuccessful. Refer to interviews with the House Manager (HM) on 12/13/21 at 4:20pm. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. b. Review of Resident #3's current FL-2 dated 07/15/21 revealed there was an order for duloxetine (used to treat depression) 30mg three times a day. Review of Resident #3's subsequent physician orders dated 11/11/21 revealed there was an order for duloxetine 30mg take one capsule once daily. Review of Resident #3's record revealed there were no new orders or order changes in Resident #3's record for duloxetine between the FL-2 dated 07/15/21 and the physician orders dated 11/11/21. Review of Resident #3's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for duloxetine 30mg take 1 capsule once daily. -There was documentation that duloxetine 30mg	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PULLIAM FAMILY CARE HOME

809 WEST MINNEOLA ROAD

GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 67 was administered every day at 8:00am from 10/01/21 through 10/31/21. Review of Resident #3's November 2021 eMAR revealed: -There was an entry for duloxetine 30mg take 1 capsule once daily. -There was documentation duloxetine 30mg was administered from 11/01/21 through 11/06/21, and from 11/13/21 through 11/31/21. -There was no documentation duloxetine was administered from 11/07/21 through 11/12/21 and no documented reason why duloxetine was not administered. Observation of medications on hand for Resident #3 on 12/13/21 at 10:00am revealed there was a medication bubble pack for duloxetine 30mg take 1 capsule daily and dispensed on 11/03/21 with a quantity of 30 capsules and there were 7 capsules remaining. Telephone interview with a representative from the facility's contracted pharmacy on 12/14/21 at 10:30am revealed: -There was an order on file for duloxetine 30mg take one capsule daily dated 07/27/21 for Resident #3. -The order started on 07/27/21 when their pharmacy took over dispensing medications for the facility. -When the pharmacy received a new medication order, it was either faxed to them by the prescriber or the facility, or an electronic prescription was sent by the provider. -The pharmacy would then enter the order on the eMAR and the facility would need to verify the order for the order entry to become active on the eMAR.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 68 Interview with the SIC/MA on 12/13/21 at 2:44pm revealed: -She never missed giving Resident #3 any of his doses of medication. -She did not know why there was missing documentation on the eMAR for duloxetine from 11/07/21 through 11/12/21. She thought she documented administering medication during that time and the documentation just was not showing up on the eMAR. -There was no process in place for other staff to audit the eMAR and check her documentation and she did not complete audits either; she did not know who was responsible for completing audits. -She did not know the FL-2 order was for 30mg three times daily but the order on the eMAR was for 30mg once daily. Interview with Resident #3 on 12/14/21 at 9:34am revealed: -He did not know if he was administered duloxetine. -He received medications every day but was not sure what duloxetine was or what duloxetine looked like. -He did not know if he ever missed doses of medications because he did not count his pills when they were given to him. Interview with the Acting Administrator on 12/14/21 at 11:25am revealed: -She was not aware of Resident #3 missing documentation of medication administration for duloxetine. -The MA should not be administering any medication unless it was entered on the eMAR and matched the physician's order. -The MA should be checking each medication against the eMAR during the medication pass	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 330	Continued From page 69 and documenting the administration as soon as Resident #3 took his medication. Telephone interview with Resident #3's previous primary care provider (PCP) on 12/14/21 at 3:20pm revealed: -He had been the PCP for Resident #3 until July 2021 when the facility changed to a different provider. -He wrote the order for duloxetine 60mg daily on 06/07/21. -He did not order duloxetine to be administered 30mg once daily. Attempted telephone interview with Resident #3's current PCP on 10/14/21 at 8:42am was unsuccessful. Refer to interviews with the House Manager (HM) on 12/13/21 at 4:20pm. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 1:53pm. Interview with the HM on 12/13/21 at 4:20pm revealed: -She started her role as House Manager in October 2021. -Up to that point, the pharmacy was doing medication reviews, but there was no other process in place for staff to audit order charges compared to the eMAR. -It was part of her role as House Manager to perform medication order audits, but she had not had the chance to complete an audit yet since she just finished her job training. -She did not know residents' medications were not administered as ordered. Telephone interview with the AA on 12/14/21 at	C 330			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 330	Continued From page 70 1:53pm revealed: -When a resident had a visit with a doctor, the SIC/MA was responsible for reviewing the paperwork for new orders or order changes. -The SIC/MA was supposed to compare the medication orders received with the current eMARs to identify new, changed or discontinued medications. -There was no system in place for checking behind the SIC/MA to ensure incoming orders were reviewed and compared with the medication on the current eMARs to identify new, changed or discontinued medications and ensure medications would be administered as ordered. The facility failed to ensure 3 of 3 sampled residents' medications were administered as ordered related to insulin being administered incorrectly; failing to administer an antibiotic and an expectorant as ordered for post hospitalization treatment for pneumonia; failed to discontinue a blood pressure medication as ordered and a potassium supplement (#2); a resident not administered memantine as ordered (#1); and a resident not receiving an anti-anxiety and anti-depressant medications as ordered (#3). This failure 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 12/13/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2022.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PULLIAM FAMILY CARE HOME

**809 WEST MINNEOLA ROAD
GIBSONVILLE, NC 27249**

(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 342	Continued From page 71	C 342		
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 #1). The findings are: Review of Resident #1's current FL2 dated 07/15/21 revealed diagnoses included type 2 diabetes, bipolar depression and stage 3 chronic kidney disease.	C 342	12/16/21 Staff will document all medications given, refused, dropped or missing, as soon as the medication is observed being taken by the resident. Administrator will review records on a daily basis for accuracy and then weekly thereafter.	

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STATE FORM

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 342	Continued From page 72 a. Review of Resident #1's physician's orders dated 12/09/21 revealed there was no order for loratadine (used to treat symptoms of allergies) 10mg take one tablet daily. Observation of medications on hand on 12/13/21 at 10:00am revealed: -There was a bottle of tablets labeled loratadine 10mg take one tablet daily with a dispensed date of 12/09/21 for 30 tablets. -There were several tablets remaining in the bottle. Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed there was no entry for loratadine 10mg on the eMAR. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/13/21 at 2:44pm revealed: -Resident #1 had a virtual visit with a doctor other than his primary care provider (PCP) the week prior because he had a cold, and he was prescribed loratadine after that visit. -She was responsible for updating medication orders on the eMAR, but she was not knowledgeable on the charting system, so she did not add the new orders to his eMAR because she did not know how. -There was no process in place for another staff to audit order changes against the orders in the eMAR system. -She had not received an after-visit summary from the virtual doctor appointment, so she was administering the medications based on the instructions on the medication bottles and not documenting the administrations. Telephone interview with a nurse from Resident	C 342			

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C 342	Continued From page 73 #1's acute care provider's office on 10/14/21 at 9:00am revealed: -They had completed a virtual visit with Resident #1 the week prior on 12/09/21 and diagnosed Resident #1 with an upper respiratory tract infection. -The doctor had ordered the loratadine 10mg daily and had electronically prescribed those medications to the pharmacy. -They had faxed the appointment notes to the facility but were unsure who specifically the fax went to. Telephone interview with a representative from the pharmacy on 12/14/21 at 10:20am revealed: -They were not Resident #1's primary pharmacy but had filled short-term medications for him in the past. -They received an order for loratadine 10mg daily on 12/09/21 from a local provider and dispensed the medications that day on 12/09/21. Interview with the Acting Administrator on 12/14/21 at 11:25am revealed: -The MA should not be administering any medication unless it was entered on the eMAR. -The MA should be checking each medication against the eMAR during medication pass and documenting the administration as soon as Resident #1 took his medication. -They did not have a process in place for auditing the eMARs or medications. Attempted telephone interview with Resident #1's PCP on 12/14/21 at 9:02am was unsuccessful. b. Review of Resident #1's physician's orders dated 12/09/21 revealed there was no order for amoxicillin (an antibiotic) 875mg take one tablet twice a day.	C 342			

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C 342	Continued From page 74 Observation of medications on hand on 12/13/21 at 10:00am revealed: -There was a bottle of tablets labeled amoxicillin 875mg take one tablet twice a day with a dispensed date of 12/09/21 for a quantity of 14 tablets. -There were 6 tablets remaining in the bottle. Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed there was no entry for amoxicillin 875mg tablets on the eMAR. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 12/13/21 at 2:44pm revealed: -Resident #1 had a virtual visit with a doctor other than his primary care provider (PCP) the week prior because he had a cold, and he was prescribed amoxicillin after that visit. -She was responsible for updating medication orders on the eMAR, but she was not knowledgeable on the charting system, so she did not add the new orders to his eMAR because she did not know how. -There was no process in place for another staff member to audit order changes against the orders in the eMAR system. -She had not received an after-visit summary from the virtual doctor appointment, so she was administering the medications based on the instructions on the medication bottles and not documenting the administrations. Telephone interview with a nurse from Resident #1's acute care provider's office on 10/14/21 at 9:00am revealed: -They had completed a virtual visit with Resident #1 the week prior on 12/09/21 and diagnosed	C 342		

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C 342	Continued From page 75 Resident #1 with an upper respiratory tract infection. -The doctor had ordered amoxicillin 875mg twice daily and had electronically prescribed those medications to the pharmacy. -They had faxed the appointment notes to the facility but were unsure who specifically the fax went to. Telephone interview with a representative from the pharmacy on 12/14/21 at 10:20am revealed: -They were not Resident #1's primary pharmacy but had filled short-term medications for him in the past. -They received an order for amoxicillin 875mg twice daily on 12/09/21 from a local provider and dispensed the medications that day on 12/09/21. Interview with the Acting Administrator on 12/14/21 at 11:25am revealed: -The MA should not be administering any medication unless it was entered on the eMAR. -The MA should be checking each medication against the eMAR during medication pass and documenting the administration as soon as Resident #1 took his medication. -They did not have a process in place for auditing the eMARs or medications. Interview with Resident #1 on 12/14/21 at 11:36am revealed: -He had a virtual appointment with a provider the previous week because he had respiratory symptoms. -The doctor had send prescriptions to the pharmacy for him and he thought one was an antibiotic but he did not know what his medication orders were. -He did not know if he had been receiving his new prescriptions or not.	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 342	Continued From page 76 Attempted telephone interview with Resident #1's PCP on 12/14/21 at 9:02am was unsuccessful.	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration and disposition of controlled substances for 2 of 3 sampled residents (Residents #2 and #3) who received narcotic anti-anxiety medications. The findings are: 1. Review of Resident #3's current FL-2 dated 07/15/21 revealed: -Diagnoses included schizophrenia and mild intellectual disability. -There was an order for lorazepam (a narcotic used to treat anxiety) 0.5mg three times daily. Review of Resident #3's physician order dated 03/15/21 revealed there was an order to change lorazepam from 0.5mg three times daily to 1mg three times daily.	C 367	Staff will ensure all controlled substances are logged correctly in the electronic MAR as well as in the controlled substance log located in the home. The Administrator will check the electronic MAR for accuracy on a daily basis, and the paper controlled log on a weekly basis for accuracy.	12/16/21

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NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
(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 367	Continued From page 77 Review of Resident #3's physician order dated 11/05/21 revealed there was an order to change lorazepam from 1mg three times daily to 0.5mg three times daily. Review of Resident #3's physician order medication list dated 11/11/21 revealed there was an order for lorazepam 0.5mg take 1 tablet three times daily. Review of Resident #3's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg three times daily at 8:00am, 2:00pm and 8:00pm. -Lorazepam 1mg was administered three times daily at 8:00am, 2:00pm and 8:00pm from 10/01/21 through 10/31/21. -There was no documented administration of lorazepam on 10/23/21 at 8:00pm and 10/26/21 at 8:00pm with no documented explanation why lorazepam was not administered. Review of Resident #3's November 2021 eMAR revealed: -There was an entry for lorazepam 1mg three times daily at 8:00am, 2:00pm, and 8:00pm, with a discontinue date of 11/05/21. -Lorazepam 1mg was documented as administered three times daily at 8:00am, 2:00pm and 8:00pm from 11/01/21 through the 8:00am dose on 11/04/21. There was no reason documented for missing the 2:00pm or 8:00pm doses on 11/04/21. -There was an entry for lorazepam 0.5mg three times daily at 8:00am, 2:00pm, and 8:00pm, with a start date of 11/06/21. -Lorazepam 0.5mg was documented as administered three times daily at 8:00am, 2:00pm and 8:00pm from 11/13/21 through 11/30/21.	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL041031

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____

B. WING: _____

(X3) DATE SURVEY
COMPLETED

C

12/14/2021

NAME OF PROVIDER OR SUPPLIER

PULLIAM FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

809 WEST MINNEOLA ROAD

GIBSONVILLE, NC 27249

(X4) ID
PREFIX
TAG

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DEFICIENCY)

(X5)
COMPLETE
DATE

C 367

Continued From page 78

-There was no documentation lorazepam 1mg was administered from 11/06/21 through 11/12/21 and no documented reason why.

Review of Resident #3's December 2021 eMAR revealed:

-There was an entry for lorazepam 0.5mg three times daily at 8:00am, 2:00pm, and 8:00pm.

-Lorazepam 0.5mg was documented as administered three times daily at 8:00am, 2:00pm and 8:00pm from 12/01/21 through 12/12/21.

Review of Resident #3's CSCS for October November and December 2021 revealed there were no CSCS documentation for review.

Observation of medication on hand on 12/13/21 at 10:00am for Resident #3 revealed:

-There was a bubble pack labeled lorazepam 0.5mg take 1 tablet three times daily, with a dispense date of 12/06/21 with 15 tablets remaining out of 30 tablets.

-There was a controlled substance count sheet (CSCS) attached to the medication bubble pack with a rubber band, and there was no documentation on the CSCS.

Interview with the

Supervisor-In-Charge/medication aide (SIC/MA) on 12/13/21 at 2:44pm revealed:

-She had worked every day, every shift, since mid-October and was familiar with Resident #3's medications.

-She administered Resident #3's lorazepam three times a day at 8:00am, 2:00pm and 8:00pm.

-She did not know why there was no documented administrations on the eMAR from 11/04/21 through 11/12/21.

-She knew she was supposed to document each tablet of lorazepam administered on the CSCS to

C 367

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 367	Continued From page 79 keep a count of the medication but chose not to fill it in; she had no explanation why. Interview with Resident #3 on 12/14/21 at 9:34am revealed: -He was familiar with his medications by their appearance only. -He did not always look at the medications he was taking to verify they were all there. -He did not know if he had ever missed doses of his anxiety medication. Telephone interview with a pharmacist at the facility-contracted pharmacy on 12/14/21 at 10:30am revealed: -They had last dispensed lorazepam 1mg tablets on 09/09/21 with a quantity of 90 tablets which was a one-month supply. -They had dispensed lorazepam 0.5mg tablets on 11/05/21 with a quantity of 90 tablets and on 12/06/21 with a quantity of 90 tablets. -Each bubble pack dispensed for a controlled medication was sent to the facility with a CSCS for keeping a count of the pills. -When a medication order changed, either the facility or the primary care physician (PCP) would fax the order to them, or the doctor would send an electronic prescription to them with the order change. Based on observation of medication on hand, review of documentation of administration on the November and December 2021 eMARs, no documentation on the CSCS, and interview with the contracted pharmacy, it could not be determined if the amount of lorazepam 0.5mg tablets available for administration was accurate. Attempted telephone interview with Resident #3's primary care physician (PCP) on 12/14/21 at	C 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 12/14/2021
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C 367	Continued From page 80 8:42am was unsuccessful. Refer to telephone interview with the Acting Administrator (AA) on 12/14/21 at 11:25am. 2. Review of Resident #2's current FL2 dated 10/21/21 revealed: -Diagnoses included diabetes, hypertension, schizoaffective disorder, and hypothyroidism. -There was an order for clonazepam 1mg twice daily (used to treat bipolar disorder). Review of Resident #2's physician's order sheet dated 11/11/21 revealed there was an order for clonazepam 1mg twice daily. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for clonazepam 1mg twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation clonazepam 1mg was administered twice daily for 26 days from 10/01/21 through 10/31/21. -There were 2 dates the resident refused clonazepam 1mg on 10/05/21 and 10/07/21. -There were 3 dates with no documentation why the medication was not administered. Review of Resident #2's controlled substance count sheet (CSCS) for October 2021 revealed the CSCS sheet was blank and had not been completed from 10/01/21 through 10/31/21. Review of Resident #2's November 2021 eMAR revealed: -There was an entry for clonazepam 1mg twice daily scheduled for administration at 8:00am and 8:00pm.	C 367			

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C 367	Continued From page 81 -There was documentation clonazepam 1mg was administered twice daily 21 days from 11.01/21 through 11/30/21. -Two days the resident refused clonazepam 1mg twice daily on 11/02/21 and 11/03/21. -There were 7 dates that there was no documentation why the medication was not administered Review of Resident #2's CSCS for November 2021 revealed the CSCS sheet was blank and had not been completed from 11/01/21 through 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for clonazepam 1mg twice daily scheduled for administration at 8:00am and 8:00pm. -There was documentation clonazepam 1mg was administered twice daily from 12/01/21 through 12/12/21. Review of Resident #2's CSCS for December 2021 revealed the CSCS sheet was blank and had not been completed from 12/01/21 through 12/13/21. Observation of Resident #2's medications on hand at the facility on 12/13/21 at 11:35am revealed: -There were two cards of clonazepam 1mg was available for administration. -There were 30 tablets remaining in one card and 30 tablets remaining in the second card. Based on review of documentation on the October, November and December 2021 eMARs, no documentation on the CSCS and observation of medication on hand, it could not be determined	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

FCL041031

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

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(X3) DATE SURVEY
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C
12/14/2021

NAME OF PROVIDER OR SUPPLIER

PULLIAM FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

809 WEST MINNEOLA ROAD
GIBSONVILLE, NC 27249

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COMPLETE
DATE

C 367

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if the amount of clonazepam 1mg available for
administration was accurate.

Telephone interview with a representative from
the facility's contracted pharmacy on 12/14/21 at
10:30am revealed:

-The pharmacy sent the CSCS with medications
when they were sent from the pharmacy to the
facility.

-The facility was responsible to use the CSCS
along with the residents' eMARs to assist with
tracking receipt and administration of controlled
medications.

Interview with the
Supervisor-In-Charge/medication aide (SIC/MA)
on 12/13/21 at 11:40am revealed:

-When she administered Resident #2's
clonazepam 1mg twice daily she did not complete
the CSCS.

-She was aware that she was required to
complete the form.

-She had no explanation or reason why she did
not complete the CSCS.

Interview with the acting Administrator on
12/14/21 at 2:38pm revealed:

-The SIC was aware that she was supposed to
use the CSCS sheets when administering
Resident #2's clonazepam.

-She visited the facility monthly but did not check
the CSCS sheets and the eMARs.

-The facility did not have a system in place to
compare CSCS with the eMAR to ensure
controlled medications were properly documented
and accounted for.

Refer to telephone interview with the Acting
Administrator (AA) on 12/14/21 at 11:25am.

C 367

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C 367	Continued From page 83 Telephone interview with the AA on 12/14/21 at 11:25am revealed: -It was her expectation that the SIC/MA administer all medications as ordered, and document on the eMAR. -She expected the SIC/MA to keep an accurate account of the controlled substance medications by documenting each tablet removed from the bubble pack on the CSCS sheet.	C 367		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to submit a report of allegations of verbal abuse by Staff A to the Health Care Personnel Registry (HCPR) within 24 hours of becoming aware of allegations that Staff A cursed and yelled at residents. The findings are: Observations on of Staff A on 12/13/21 at 1:10pm revealed: -When standing outside the facility, 20 feet from the facility, Staff A could be heard loudly yelling at a resident. -Staff A said things like: "they don't want you, I	C 428	All staff will have a HCPR check upon hire and every 6 months thereafter. The Administrator will ensure that checks are completed upon hire and every 6 months.	12/16/21

Division of Health Service Regulation

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C 428	Continued From page 84 keep telling you the same thing over and over," and lastly, she said "you need to learn to get along." -The resident was not heard saying anything. Interview with a resident on 12/14/21 at 10:55am revealed: -Staff A, Supervisor-In-Charge/medication aide (SIC/MA) was not nice to him. -In the mornings she woke him up between 6:30am and 7:00am to take medications. -When she woke him up, she yelled at him and she cursed at him. -When she cursed, it made him upset that she yelled and cursed at him. -He had told the acting Administrator about Staff A yelling and cursing at him, but nothing was done, Staff A continued to yell and curse at him. Interview with a second resident on 12/14/21 at 9:34am revealed: -Staff A yelled at him almost every morning. -In the morning, he liked to take his coffee outside and drink it while sitting on the porch. -She yelled at him and told him he had to crink the coffee at the kitchen table and not sitting on the front porch. -Most of the time when he was being yelled at it was because he was moving too slow to go and do what she wanted him to do such as get in the shower. -He moved slow because he had a stroke. -It bothered him to be yelled at and it made him feel like he was not wanted at the facility. Interview with a third resident on 12/13/21 at 9:15am revealed: -Staff A treated him different from the other residents by not talking to him nice and not communicating with him the way he observed her	C 428		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PULLIAM FAMILY CARE HOME

**809 WEST MINNEOLA ROAD
GIBSONVILLE, NC 27249**

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C 428	Continued From page 85 communicate with some of the other residents. -He wanted Staff A to be nice to him and talk with him, but she would not. Interview with Staff A on 12/14/21 at 9:44am revealed: -She did not treat residents mean, yell or curse at them. -She was hard of hearing and sometimes when she talked her voice sounded loud. Interview with the Acting Administrator on 12/13/21 at 1:23pm revealed: -Twice, a couple of months ago, she physically visited the facility to have a conversation with the SIC/MA because the residents complained to her that Staff A yelled and cursed at them. -Each time she talked with Staff A and told her to treat residents with respect. -She had Staff A complete residents' rights training at the end of October 2021. -She had not reported Staff A to the HCPR because she did not know the incidents had to be reported.	C 428		
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	Staff are educated on residents rights and the importance of following them upon hire, and re-educated every 6 months. Administrator will ensure residents rights are being followed on a weekly basis.	12/16/21

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C 912	Continued From page 86 federal and state laws and rules and regulations related to management and other staffing, medication administration and Ach medication aides; training and competency. The findings are: 1. Based on observations the Administrator failed to ensure the management and total operations of the facility were maintained to ensure compliance with the rules and statutes of adult care homes to protect each resident's rights to receive adequate and appropriate care and services related to test for tuberculosis, other staff qualifications, competency validation for licensed health, training on care of diabetic residents, health care, licensed health professional support, nutrition and food service, residents' right, medication orders, medication administration, health care personnel registry, controlled substance, Adult Care Homes medication aides training and competency, and examination and screening for controlled substances. [Refer to Tag 185 10A NCAC 13G.0601 Management and Other Staffing (Type B Violation)]. 2. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 3 of 3 sample residents (Residents #1, #2, and #3) related to insulin administration, an antibiotic, an expectorant, multi-vitamins and administered discontinued medications for blood pressure and a potassium supplement (#2), a resident not administered a receptor antagonist medication (#1), and a resident not administered an anti-anxiety medication and an anti-depressant medication (#3). [Refer to Tag 330, 10A NCAC 13G.1004(a) Medication Administration (Type B	C 912		

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C 912	Continued From page 87 Violation)). 3. Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) who administered medications to residents had completed the medication administration competency validation clinical skills checklist prior to administering medications to the residents. [Refer to Tag 935 G.S. 131D-4.5B(b) Ach Medication Aides; Training and Competency (Type B Violation)].	C 912		
C 914	G.S. 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of verbal abuse. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 4 sampled residents (Residents #2, #3 and #4) were treated with respect, dignity, and free of verbal abuse by Staff A who cursed and yelled at the residents. [Refer to Tag 0311, 10A NCAC 13G .0909 Residents' Rights (Type B Violation)].	C 914	12/14/21 Staff are educated on residents rights and the importance of them following them, upon hire, and re-educated every 6 months. Administrator will ensure residents rights are being followed on a weekly basis.	
C935	G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	C935	All staff will have the appropriate training by personnel prior to performing task in the home. All trainings will be placed in personal file for immediate review. Administrator will ensure	

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C935	Continued From page 88 (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION	C935	all staff compliance needs are current and accurate. This will be upon hire and on a monthly basis with record review.	

Division of Health Service Regulation

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C935	Continued From page 89 Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) who administered medications to residents had completed the medication administration competency validation clinical skills checklist prior to administering medications to the residents. The findings are: Review of Staff A's, Supervisor-In-Charge (SIC)/MA personnel record revealed: -There was no documentation of Staff A's date of hire or title. -Staff A passed the written medication exam on 07/25/2014. -There was no documentation Staff A had completed the required medication administration competency validation clinical skills checklist. -There was documentation Staff A completed the 15 hours of medication aide training on 09/12/2015. -There was documentation Staff A passed the medication aide examination on 07/25/14. Review of a resident's October, November and December 2021 electronic medication administration record (eMAR) revealed Staff A documented medications were administered to the residents daily from 10/01/21 to 12/14/21. Interview with a resident on 12/31/21 at 9:05am revealed: -Staff A administered his medications daily. -Staff A checked his blood sugars and administered insulin. Interview with a second resident on 12/13/21 at 9:15am revealed Staff A was the only staff at the facility, and she administered residents their	C935		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
(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
C935	Continued From page 90 medications. Interview with Staff A on 12/14/21 at 9:47am revealed: -She started working at the facility in June 2021, as the live-in SIC/MA. -Her responsibilities included administering medications to the residents. -She was the only staff at the facility that administered medications to the residents. -She had not had any medication aide related training since she started working at the facility. Interview with the Acting Administrator on 12/14/21 at 11:09am revealed: -Staff A was a live-in staff at the facility. -Staff A's responsibilities included administering medications to the residents. -She was unaware Staff A had not completed the medication administration competency validation clinical skills checklist. -When she took over the operations of the facility, Staff A was already employed. -She thought the previous owner had Staff A complete the required training. -She did not check Staff A's record to ensure she had completed the required trainings because she did not hire Staff A. [Refer to Tag 0330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)]. [Refer to Tag 0315 10A NCAC 13G .1002(a) Medication Orders]. [Refer to Tag 0367 10A NCAC 13G 1008(a) Controlled Substances]. The facility failed to ensure 1 of 2 sample staff (Staff A) who administered medications	C935		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 12/14/2021
NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C935	Continued From page 91 completed the medication administration competency validation clinical skills checklist prior to administering medications resulting in errors in medication administration. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. A plan of protection was requested on 01/04/22 in accordance with G.S. 131D-34 for this violation and not provided. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 29, 2022.	C935		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every	C992	12/14/21 All staff will have a drug screening completed prior to beginning work at the home. This will be placed in staff file for immediate review. The Administrator will ensure drug screening is completed upon hire and randomly thereafter.	

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NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C992	Continued From page 92 controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 staff (Staff A) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: Review of Staff A's, Supervisor-In-Charge/medication aide (SIC/MA) personnel record revealed: -There was no documentation of a hire date for Staff A. -There was no documentation Staff A had a controlled substance examination and screening upon hire. Interview with Staff A on 12/14/21 at 9:47am revealed: -She started working at the facility in June 2021. -When she was hired, she did not have an examination and screening for the presence of controlled substances. -She had previously worked at the facility and thought she did not need any new paperwork.	C992		

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NAME OF PROVIDER OR SUPPLIER PULLIAM FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 809 WEST MINNEOLA ROAD GIBSONVILLE, NC 27249		
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C992	Continued From page 93 Telephone interview with the Acting Administrator (AA) on 12/14/21 at 11:09am revealed: -She did not know Staff A had not completed a controlled substance examination and screening upon hire. -She thought the previous owner had Staff A complete a controlled substance examination and screening. -She did not check Staff A's record because Staff A was hired at the facility prior to her taking over the operations of the facility.	C992		