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{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 ensure the referral and follow-up to meet the routine healthcare needs for 2 of 2 residents sampled (#1, #3) with a podiatry appointment for a diabetic (#1) and for a referral to a podiatrist appointment (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 07/15/21 revealed diagnoses included hypertension, asthma, and schizoaffective disorder. Review of a visit summary from Resident #3's primary care provider (PCP) dated 07/06/21 revealed Resident #3 was referred to a podiatrist for evaluation and treatment. Interview with Resident #3 on 03/18/22 at 11:18am revealed: -He did not know why the PCP referred him to a podiatrist. -He cut his own toenails. -His fee did not hurt, itch or burn. -He had a bad toenail a long time ago, but he did not have a problem with it anymore. Telephone interview with the podiatrist office on 03/18/22 at 10:10am revealed Resident #3 was referred to their office but had never been seen because they were not contacted by the facility to schedule an appointment.	{C 246}		

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{C 246}	Continued From page 1 Interview with the Medication Aide (MA) on 03/18/22 at 11:04am revealed: -She did not make the physicians appointments; but she had a calendar that she kept the appointments on. -She had only worked at the facility for about a month, so she had not made appointments for the residents. -She will make the physicians' appointments for the residents once she is trained. Interview with the Administrator on 03/18/22 at 10:49am revealed: -Resident #3 was seen by the PCP and he not seen by any other physicians. -She did not know Resident #3 had a referral from the PCP for a podiatrist evaluation and treatment. -She would have made an appointment with a podiatrist for Resident #3, but she had not seen the referral. -She had seen Resident #3's feet but did not see any reasons to be concerned; his feet were a little dry and needed lotion. -Resident #3 did not complain about his feet. -She was responsible for making the physicians' appointments for the residents but once the MA was trained it would become her responsibility. Attempted telephone interview with Resident #3's PCP on 03/18/22 at 9:57am was unsuccessful. Attempted telephone interview with Resident #3's previous PCP on 03/18/22 at 9:52am was unsuccessful. 2. Review of Resident #1's current FL-2 dated 07/15/21 revealed diagnoses of congestive heart failure, diabetes Type II,	{C 246}		

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{C 246}	Continued From page 2 schizoaffective disorder hypertension and bilateral leg edema. Observation of Resident #1's feet on 03/17/22 at 12:35pm revealed: -The resident's ankles, feet and toes were swollen and were covered with white flecks of dry skin. -The resident's toenails curved under at the tips and were grayish yellow in color. -The residents' big toenails were one-half inch long past the end of his toe and was curved to the inside of his foot. Interview with Resident #1 on 03/18/22 at 9:50am revealed: -No one took care of his feet, he had not seen a podiatrist to have his toenails trimmed. -He knew his toenails too long but they did not bother him because he went barefooted of wore flip Interview with the MA on 03/17/22 at 12:40pm revealed: -She had been working at the facility for 1 month and had seen Resident #1's feet, ankles and toes. -Resident #1 usually went barefooted or wore flip-flop shoes. -Resident #1 did not like to wear socks or wear shoes. -She trimmed his fingernails and filed them, but he had diabetes and she did not trim his toenails. -She was not aware if Resident #1 had a podiatrist to trim his toenails or had an appointment to go to a podiatrist. -The Administrator made the residents' appointments. Review of the Licensed Health Professional	{C 246}		

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{C 246}	Continued From page 3	{C 246}		

Support (LHPS) reviews for 05/10/21 and 10/14/21 revealed:
-Resident #1 had tasks of finger stick blood sugare (FSBS) checks and insulin injections but no documentation of the condition of -Resident #1's ankles, feet or toes.
-There was no documentation of recommendations for podiatry care for Resident #1.

Review of Resident #1's record revealed there were no orders for podiatry care for Resident #1

Interview with Resident #1 on 03/18/22 at 9:50am revealed:
-No one helped to take care of his feet.
-He knew his toenails were long but they did not bother him because he went barefooted most of the time when he was inside and he wore flip-flops year around inside the house and outside.
-He had a PCP, but was never given an appointment to see a podiatrist.

Attempted telephone interview with Resident #1's PCP on 03/18/22 at 8:49am was unsuccessful.

Attempted telephone interview with Resident #1's Guardian on 03/18/22 at 11:30am was unsuccessful.

Interview with the Administrator on 03/18/22 at 10:30am revealed:
-She had worked at the facility about 1 year.
-Resident #1 had not had podiatryservices during that time.
-The MA should have made an appointment for Resident #1 to see the podiatrist for nail care.
-The previous PCP told her to make a podiatry appointment for Resident #1 but she did not

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{C 246}	Continued From page 4 follow-up and make an appointment. -Resident #1's toenails were too long and needed to be trimmed. -She had been in the process of changing PCP services and Resident #1 would be assessed by a new PCP on Monday (03/21/22) with services including podiatry care.	{C 246}		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure implementation of orders for 2 of 3 residents sampled to complete blood pressure (BP) checks weekly (#2) and BP checks on the 1st and the 15th of the month (#3) as ordered by the Primary Care Physician (PCP). The findings are: 1. Review of Resident #2's current FL-2 dated 07/15/21 revealed: -Diagnoses included seizure disorder, history of cerebral vascular accident (CVA), anemia and chronic aspiration. -Resident #2's blood pressure (BP) was to be checked weekly.	C 249		

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C 249	Continued From page 5 Review of Resident #2's January 2022 electronic Medication Administration Record (eMAR) revealed there was not an entry documented for BP checked weekly. Review of Resident #2's February 2022 (eMAR) revealed there was not an entry documented for BP checked weekly. Review of Resident #2's March 2022 (eMAR) revealed there was not an entry documented for BP checked weekly. Interview with Resident #2 on 03/18/22 at 9:47am revealed: -His BP was not checked by the staff at the facility. -He had never had his BP checked weekly by the staff at the facility. -He had his BP checked at his primary care provider's (PCP) office, but he could not recall when his last visit was. Telephone interview with Resident #2's family member on 03/17/22 at 3:21pm revealed resident #2 had an order for weekly BP checks but she thought the order had been discontinued a long time ago. Interview with the Medication Aide (MA) on 03/18/22 at 11:04am revealed: -She had reviewed some of the resident's FL-2s when she started to work at the facility about one month ago. -She did not know Resident #2 had an order for weekly BP checks. -BP checks for all the residents were done once a month and documented in a logbook. Telephone interview with the Administrator on	C 249		

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C 249	Continued From page 6 03/18/22 at 10:43am revealed: -The residents' BP checks were documented under notes and not on the eMAR. -The residents' BP checks were done monthly as part of their vitals. -She was not familiar with Resident #2's order for weekly BP checks. -The MA was supposed to review the residents' FL-2s and ensure the orders were followed. -If there was no documentation for Resident #2's weekly BP checks then they were not considered done. -The FL-2 was an order and she expected the staff to follow the orders. Attempted telephone interview with Resident #2's PCP on 03/18/22 at 9:52am was not successful. 2. Review of Resident #3's current FL-2 dated 07/15/21 revealed: -Diagnoses included hypertension, asthma, schizoaffective disorder. -Resident #3's blood pressure (BP) was to be checked twice monthly on the first and the fifteenth. Review of Resident #3's January 2022 electronic Medication Administration Record (eMAR) revealed there was not an entry documented for BP checked twice monthly on the first and the fifteenth. Review of Resident #3's February 2022 (eMAR) revealed there was not an entry documented for BP checked twice monthly on the first and the fifteenth. Review of Resident #3's March 2022 (eMAR) revealed there was not an entry documented for BP checked twice monthly on the first and the	C 249		

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C 249	Continued From page 7 fifteenth. Interview with Resident #3 on 03/18/22 at 12:01pm revealed he could not recall the last time he had his BP checked by the MA. Interview with the Medication Aide (MA) on 03/18/22 at 11:04am revealed: -She had reviewed some of the resident's FL-2s when she started to work at the facility about one month ago. -She did not think she had reviewed Resident #3's FL-2 -She did not know Resident #3 had an order for BP checks twice weekly on the first and the fifteenth of the month. -BP checks for all the residents were done once a month and documented in a logbook. Telephone interview with the Administrator on 03/18/22 at 10:43am revealed: -The residents' BP checks were documented under notes and not on the eMAR. -The residents' BP checks were done monthly as part of their vitals. -She was not familiar with Resident #3's order for BP checks twice monthly on the first and the fifteenth of the month. -The MA was supposed to review the residents' FL-2s and ensure the orders were followed. -If there was no documentation for Resident #3's BP checks twice monthly then they were not considered done. -The FL-2 was an order and she expected the staff to follow the orders. Attempted telephone interview with Resident #3's primary care provider's (PCP) on 03/18/22 at 9:52am was not successful.	C 249		

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{C 274}	Continued From page 8	{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 03/17/22 at 8:48am revealed there was no citrus juice or fruit juice available for serving to the residents. Observation of the facility on 03/17/22 at 1:09pm revealed groceries were delivered to the facility; fruit juice was not delivered with the groceries. Review of the 7-day week-at-glance menu provided by the facility on 03/17/22 at 9:00am revealed fruit juice was to be served with the breakfast meal every day for the next seven days. Interview with a resident on 03/17/22 at 8:50am	{C 274}		

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{C 274}	Continued From page 9 revealed: -He did not get fruit juice with the breakfast meal every morning. -He liked fruit juice and would like to have fruit juice every day. -He had not had fruit juice since he had been admitted to the facility in August 2021. Interview with a second resident on 03/17/22 at 9:06am revealed: -He was served fruit juice about once a month. -He would like to have fruit juice once daily. -He would like to have fruit juice every day. Interview with a third resident on 03/17/22 at 9:15am revealed: -He normally did not get fruit juice to drink from the facility. -He liked fruit juice and would like to have fruit juice more often. -It had been awhile since he had fruit juice. Interview with the Supervisor-In-Charge/medication aide (SIC/MA) on 03/17/22 at 9:13am and 9:45am revealed: -She was not sure about how to read the menu; it confused her. -She served fruit juice about three times a week. -The Administrator brought groceries to the facility once a week. -The last time she had had fruit juice was 03/14/22. Telephone interview with the Administrator on 03/18/22 at 10:49am revealed: -Groceries were delivered to the facility once a week; sometimes she brought the groceries. -Food items like milk, eggs and bread were brought to the facility as needed; staff were supposed to call her when they ran out of items.	{C 274}		

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{C 274}	Continued From page 10 -Fruit or fresh fruit was supposed to be served every day, but she was not aware fruit juice with 100% daily vitamin C was supposed to be served daily. -She expected the menu to be followed by the SIC/MA and if fruit juice was on the menu then she should have served it.	{C 274}		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the recording of administration medications on the medication administration record immediately following administration of the medication to the resident and observation of the resident actually taking the medication, prior to the administration of another resident's medication, was allowed for 3 of 3 sampled residents (#1, #2 and #3). The findings are: Observation of the facility on 03/17/22 at 9:15am	C 341		

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revealed:
-The kitchen table was set for breakfast with six place settings.
-Each place setting had a reusable cup; one of the cups was pink.
-Each cup had a resident's name on it and contained assorted tablets.
-The residents began to sit at the table one by one and took the medication at the place setting they sat at.
-The Medication Aide (MA) was not in the room when the residents took their medication.
-Two residents were handed inhalers by the MA; the MA left the room and did not observe the residents using the inhalers.
-One resident asked another resident which cup of medication was his.
-The MA returned to the dining room and told a resident "remember you have the only pink cup".

Observation of the MA on 03/17/22 at 10:34am revealed she was documenting medication administration for all of the residents on the medication administration records (MAR) for 2:00pm and 8:00pm medication administration for 03/16/22 and 8:00am medication administrations for 03/17/22 for all residents.

Interview with five residents on 03/17/22 at 9:16am revealed:
-Their medications were always in the plastic cups on the table for breakfast and dinner.
-Sometimes the MA was in the room and sometimes she was not.
-One resident knew his medication was in a pink cup because he was new.

1.Review of Resident #1's current FL-2 dated 12/03/21 revealed:
-Diagnosis included hypertension, schizophrenia,

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chronic bronchitis, benign prostatic hyperplasia, hyperlipidemia, arthritis, and gastroesophageal reflex disease (GERD).
-There was an order for chlorhexidine gluconate (a mouthwash used to reduce the number of bacteria) 0.12% swish and spit 5ml daily.
-There was an order for Vitamin B12 (used to keep blood cells healthy) 1000mcg daily.
-There was an order for Flonase (used to treat allergy symptoms) 50mcg instill one spray each nostril daily.
-There was an order for lisinopril (used to treat high blood pressure) 10mg twice daily.
-There was an order for lorazepam (used to treat anxiety disorders) 0.5mg once daily at bedtime.
-There was an order for tamsulosin (used to treat enlarged prostate) 0.4mg once daily at bedtime.
-There was an order for olanzapine (used to treat agitation associated with schizophrenia) 5mg once daily.
-There was an order for trazodone (an antidepressant) 100mg once daily at bedtime.
-There was an order for melatonin (used to help regulate sleep) 10mg once daily at bedtime.
-There was an order for metoprolol tartrate (used to treat high blood pressure) 25mg twice daily.
-There was an order for mirtazapine (used to treat depression) 15mg take two tables once daily at bedtime.
-There was an order for Myrbetriq (used to treat overactive bladder) 25mg once daily.
-There was an order for Senna (used to treat constipation) 8.6mg two tablets twice daily.
-There was an order for Ventolin HFA (used to prevent bronchospasms) 90mcg inhale two puffs once daily.

Review of Resident #1's March 2022 MAR on 03/17/22 at 9:40am revealed:
-Resident #1's 8:00pm medications had not been

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documented as administered on 03/16/22.
-Resident #1's 8:00am medications had not been documented as administered on 03/17/22.

Refer to interviews with the Medication Aide (MA) on 03/17/22 at 10:34am and 3:30pm.

Refer to the telephone interview with the Administrator on 03/17/22 at 5:17pm.

2. Review of Resident #2's current FL-2 dated 07/15/21 revealed:
-Diagnoses included seizure disorder, history of cerebral vascular accident (CVA), chronic obstructive pulmonary disease (COPD), anemia and chronic aspiration.
-There was an order for aspirin (used to prevent stroke) 81mg once daily.
-There was an order for folic acid (used to treat anemia) 1mg once daily.
-There was an order for cetirizine (used to treat allergy symptoms) 10mg once daily.
-There was an order for levetiracetam (used to treat seizures) 2000mg four tablets once daily.
-There was an order for Vitamin B12 (used to treat anemia) 100mg once daily.
-There was an order for chlorthalidone (used to treat hypertension) 25mg once daily.
-There was an order for Incruse Ellipta (used to treat COPD) 62.5mcm inhale one puff once daily.
-There was an order for pantoprazole (used to treat gastroesophageal reflux disease (GERD)) 40mg once daily.

Review of Resident #2's March 2022 MAR on 03/17/22 at 9:40am revealed Resident #2's 8:00am medications had not been documented as administered on 03/17/22.

Refer to interviews with the Medication Aide (MA)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041031	A. BUILDING: _____ B. WING _____	R 03/18/2022

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 341	Continued From page 14 on 03/17/22 at 10:34am and 3:30pm. Refer to the telephone interview with the Administrator on 03/17/22 at 5:17pm. 3. Review of Resident #3's current FL-2 dated 07/15/21 revealed: -Diagnoses included hypertension, asthma, schizoaffective disorder. -There was an order for acetaminophen (used to reduce pain) 500mg once daily. -There was an order for divalproex (used to treat manic depressive disorders) 500mg take four tablets once daily at bedtime. -There was an order for omeprazole (used to treat heartburn) 20mg once daily. -There was an order for a multivitamin (used to prevent vitamin deficiency) once daily. -There was an order for paliperidone (used to treat schizoaffective disorder) 6mg once daily at bedtime. -There was an order for Breo Ellipta (used to treat asthma) 200-25 inhale once daily in the morning. -There was an order for Gerri Tussin (used to treat chronic congestion) 100mg once daily at bedtime. Review of Resident #3's March 2022 MAR on 03/17/22 at 9:40am revealed: -Resident #3's 8:00pm medications had not been documented as administered on 03/16/22. -Resident #3's 8:00am medications had not been documented as administered on 03/17/22. Refer to interviews with the Medication Aide (MA) on 03/17/22 at 10:34am and 3:30pm. Refer to the telephone interview with the Administrator on 03/17/22 at 5:17pm.	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041031	A. BUILDING: _____ B. WING _____	R 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 341	Continued From page 15 Interviews with the Medication Aide (MA) on 03/17/22 at 10:34am and 3:30pm revealed: -The residents took their medications at the table. -Each resident had a cup with their name on it. -She popped the medications into each residents' cup and then placed it at their seat. -The residents always sat in the same seats at meals. -She administered all the residents their medication at one time. -She usually stood in the kitchen about three feet away so she could see "everybody" [residents] take their mediations. -She always documented mediation administrations on the medication administration record (MAR) after all the residents' medications had been administered. -She forgot to document the 8:00pm medication administration on 03/16/22 because the security alarm went off at the facility. Telephone interview with the Administrator on 03/17/22 at 5:17pm revealed: -The medication cups were not supposed to be used for setting on the table but for popping the pills from the medication cards into at the time the medication was administered. -The MA was supposed to administer medication to one resident at a time. -The MA was supposed to document the medication administration after she witnessed the resident swallow the medication. -She had observed medication administration about two weeks ago and the MA had administered and documented the medication correctly. -She was concerned the residents' medications were placed in the cups on the table because a resident with dementia could take the wrong medication and have an interaction with another	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL041031	A. BUILDING: _____ B. WING _____	R 03/18/2022

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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 341	Continued From page 16 medication or have an allergic reaction to a medication.	C 341		