STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032062	A. BUILDING: _____ B. WING _____	R-C 09/30/2021

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

(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 Licesnure Section conducted a follow-up survey on 09/30/21.	{C 000}		
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 primary care provider (PCP) notification for 1 of 3 residents (#3) who refused pain medications. The findings are: Review of Resident #3's current FL2 revealed diagnoses included degenerative joint disease, hypertension, and enlarged prostrate. a. Telephone interview with a representative at Resident #2's contracted pharmacy on 09/30/21 at 3:26pm revealed: -Resident #3 had a current order dated 09/24/21 for lidocaine 5% patches apply 1 patch to skin every day; apply once daily for up to 12 hours (12 hours on then remove for 12 hours). -lidocaine 5% patches were dispensed by the pharmacy on 09/24/21. Review of Resident #3's medication administration record (MAR) for September 2021 revealed: -There was an entry for lidocaine 5% patch apply to skin every day; apply once daily for up to 12 hours (12 hours on then remove for 12 hours scheduled to be applied at 8:00am and removed	C 246		

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C 246	Continued From page 1 at 8:00pm. -There was no documentation the lidocaine 5% patch had been applied or removed from 09/24/21 through 09/30/21. -There was no documentation on the back of the MAR regarding the reason lidocaine 5% patches had not been applied. Observation of Resident #3's medications on hand on 09/30/21 at 10:58am revealed: -There was 1 unopened box of lidocaine 5% patches dispensed by the pharmacy on 09/24/21 with a quantity of 30 patches. -The directions were to apply 1 patch to skin every day; apply once daily for up to 12 hours (12 hours on then remove for 12 hours). Interview with Resident #3 on 09/30/21 at 2:11pm revealed: -He had an order for the lidocaine patches because of pain. -He refused the lidocaine patches and had not worn them because he did not feel that they worked for him. -He always had some pain, but the pain was more in his bones and he did not think anything applied to his skin helped his pain. Interview with a Supervisor-in-Charge (SIC) on 9/30/21 at 11:00am revealed: -Resident #3's lidocaine 5% patches had not been applied since they had been dispensed by the pharmacy on 09/24/21 because Resident #3 refused them. -She had not contacted Resident #3's PCP about him refusing the lidocaine patches. -She hand delivered a note to Resident #3's PCP on yesterday, 09/29/21, which documented Resident #3 refused the lidocaine patches, but she did not have a copy of the note.	C 246		

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C 246	Continued From page 2 Telephone interview with the Nurse Case Manager at Resident #3's PCP's office on 09/30/21 at 12:37pm revealed: -Resident #3 had an order for lidocaine 5% patches for pain. -The facility had not contacted the PCP to inform Resident #3 refused his lidocaine patches. Refer to a second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with the Administrator on 09/30/21 at 3:12pm. b. Interview with Resident #3's pharmacy on 09/30/21 at 3:26pm revealed: -There was a current order dated 09/10/21 for menthol/m-salicylate 10-15% topical cream apply small amount three times a day for pain. -Menthol/m-salicylate was dispensed by the pharmacy on 09/10/21. Review of Resident #3's medication administration record (MAR) for September 2021 revealed: -There was an entry for menthol/m-salicylate 10-15% topical cream apply small amount three times a day for pain scheduled for administration at 8:00am. 2:00pm, and 8:00pm. -There was no documentation menthol/m-salicylate 10-15% had been applied from 09/26/21 at 8:00am through 09/30/21 at 8:00pm. -There was no documentation on the back of the MAR regarding the reason menthol/m-salicylate 10-15% had not been applied. Observation of Resident #3's medications on hand on 09/30/21 at 10:58am revealed:	C 246		

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C 246	Continued From page 3 -There was a boxed tube of menthol/m-salicylate 10-15% cream dispensed by the pharmacy on 09/10/21. -The directions were to apply small amount three times a day for pain. Interview with Resident #3 on 09/30/21 at 2:11pm revealed: -He had an order for pain creams, but he refused to have the cream applied by staff. -He always had some pain, but the pain was more in his bones and he did not think anything applied to his skin helped his pain. Interview with a Supervisor-in-Charge (SIC) on 9/30/21 at 11:00am revealed: -Resident #3 had pain creams that were supposed to be applied daily, but he refused to have the medication applied. -She saw Resident #3 walking slow as if in pain one day this week and offered to applied the pain cream, but Resident #3 refused. -She had not contacted Resident #3's PCP about him refusing to have pain cream applied. -She hand delivered a note to Resident #3's PCP on yesterday, 09/29/21, which documented Resident #3 refused the pain cream, but she did not have a copy of the note. Telephone interview with the Nurse Case Manager at Resident #3's PCP's office on 09/30/21 at 12:37pm revealed: -Resident #3 had an order for menthol/m-salicylate 10-15% cream for pain. -The facility had not contacted the PCP to inform Resident #3 refused his menthol/m-salicylate cream. Refer to a second interview with a SIC on 09/30/21 at 3:01pm.	C 246		

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C 246	Continued From page 4 Refer to interview with the Administrator on 09/30/21 at 3:12pm. c. Interview with Resident #3's pharmacy on 09/30/21 at 3:26pm revealed: -There was a current order dated 09/10/21 for capsaicin 0.025% apply small amount topically three times a day. -Capsaicin was dispensed by the pharmacy on 09/10/21. Review of Resident #3's medication administration record (MAR) for September 2021 revealed: -There was an entry for capsaicin 0.025% apply small amount topically three times a day scheduled for administration at 8:00am. 2:00pm, and 8:00pm. -There was no documentation capsaicin had been applied from 09/28/21 at 8:00am through 09/30/21 at 8:00pm. -There was documentation on the back of the MAR capsaicin had not been applied at 8:00pm on 09/24/21 through 8:pm, on 09/27/21 due to Resident #3 refused. Observation of Resident #3's medications on hand on 09/30/21 at 10:58am revealed: -There was a boxed tube of capsaicin 0.025% cream dispensed by the pharmacy on 09/10/21. -The directions were to apply small amount three times a day. Interview with Resident #3 on 09/30/21 at 2:11pm revealed: -He had an order for pain creams, but he refused to have the cream applied by staff. -He always had some pain, but the pain was more in his bones and he did not think anything	C 246		

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C 246	Continued From page 5 applied to his skin helped his pain. Interview with a Supervisor-in-Charge (SIC) on 9/30/21 at 11:00am revealed: -Resident #3 had pain creams that were supposed to be applied daily, but he refused to have the medication applied. -She saw Resident #3 walking slow as if in pain one day this week and offered to applied the pain cream, but Resident #3 refused. -She had not contacted Resident #3's PCP about him refusing to have pain cream applied. -She hand delivered a note to Resident #3's PCP on yesterday, 09/29/21, which documented Resident #3 refused the pain cream, but she did not have a copy of the note. Telephone interview with the Nurse Case Manager at Resident #3's PCP's office on 09/30/21 at 12:37pm revealed: -Resident #3 had an order for capsaicin 0.025% cream for pain. -The facility had not contacted the PCP to inform Resident #3 refused his capsaicin cream. Refer to a second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with the Administrator on 09/30/21 at 3:12pm. _____ A second interview with a SIC on 09/30/21 at 3:01pm revealed: -If a resident refused medication, the resident's PCP should have been notified after the resident refused for 3 days. -She did not notify Resident #3's PCP after her refused medications for 3 days and she did not know why.	C 246		

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C 246	Continued From page 6 Interview with the Administrator on 09/30/21 at 3:12pm revealed: -Residents had the right to refuse medications. -After a resident refused scheduled medications for 2 consecutive days, she expected staff to notify her of the resident's refusals. -After a resident refused scheduled medications for 3 consecutive days, she expected staff the resident's PCP or nurse manager that the resident refused and obtain a verbal order of what the PCP wanted to do regarding the refusals. -Staff had not made her aware Resident #3 had refused scheduled medications for 2 or 3 consecutive days.	C 246		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #2) related to an allergy	{C 330}		

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{C 330}	Continued From page 7	{C 330}		

medication, a pain medication, and a chemical dependence patch.

The findings are:

Review of Resident #2's current FL2 dated 04/30/21 revealed diagnoses included schizoaffective disorder bipolar type and Crohn's disease.

a. Review of Resident #2's current FL2 dated 04/30/21 revealed there was an order for fluticasone (used to treat rhinitis) 50mg nasal spray 1 spray into each nostril twice daily.

Review of Resident #2's medication administration record (MAR) for September 2021 revealed:
-There was an entry for fluticasone 50mg nasal spray 2 sprays in each nostril twice daily to be administered at 8:00am and 8:00pm.
-There was documentation 2 sprays were instilled into each nostril twice daily from 09/01/21 through 09/30/21.

Observation of Resident #2's medications on hand on 09/30/21 at 10:14pm revealed:
-There was 1 bottle of fluticasone on hand.
-There were instructions to instill 1 spray into the nostril 2 times daily with a maximum of 2 sprays in each nostril daily for allergies.
-The bottle was dispensed on 09/09/19 and there was documentation to discard after 09/09/20.
-There was more than half of the medication remaining in the bottle.

Observation of Resident #2's medication on hand 09/30/21 at 1:14pm revealed:
-There was another bottle of fluticasone on hand.
-There were instructions to instill 1 spray into the

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{C 330}	Continued From page 8	{C 330}		

nostril 2 times daily with a maximum of 2 sprays in each nostril daily for allergies.
-The second bottle of fluticasone was dispensed on 09/21/20 and there was documentation to discard after 09/21/21.
-There was more than half of the medication remaining in the bottle.

Telephone interview with a representative at Resident #2's contracted pharmacy on 07/28/21 at 12:59pm revealed:
-Resident #2's fluticasone was last filled and dispensed on 09/21/20.
-Resident #2's fluticasone should last 30 days if administered as directed.
-Fluticasone was not automatically dispensed to the facility.
-Fluticasone had to be requested by staff before it was dispensed to the facility.

Interview with Resident #2 on 09/30/21 at 2:18pm revealed:
-He suffered from allergies and he experienced nasal congestion.
-He was administered fluticasone on 09/29/21 and on 09/28/21, but he could not remember when fluticasone was administered last prior to 09/28/21.
-He was not administered fluticasone on today, 09/30/21.
-Fluticasone was not administered daily and he had to ask for it in order for staff to administer it.

Interview with the Supervisor-in-Charge (SIC) on 09/30/21 at 9:50am revealed:
-Resident #2 was to be administered fluticasone 1 spray in each nostril daily.
-She transcribed the dosage incorrectly on the MAR.
-She did not administer fluticasone to Resident #2

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daily.
-She offered fluticasone to Resident #2 daily, but sometimes he said he did not want it or did not need it.
-Last Wednesday, 09/22/21, was the last time she administered Resident #2's fluticasone.
-She was trying to get the fluticasone changed to an as needed medication.
-She had not spoken to Resident #2's primary care provider (PCP) about getting fluticasone changed to an as needed medication because his PCP was not seeing anyone due to the pandemic.
-If she needed to communicate with Resident #2's PCP regarding his medications, she took a note to his office for him to sign off on.
-She had not taken a note to Resident #2's PCP regarding changing his fluticasone to an as needed medication.
-She did not know why she had documented Resident #2's fluticasone as administered when she had not administered it.

Interview with a second SIC on 09/30/21 at 2:39pm revealed:
-He administered Resident #2's fluticasone to him on today and yesterday, 09/30/21 and 09/29/21.
-He did not know Resident #2's fluticasone was expired.
-He did not know if Resident #2 received fluticasone daily.
-No one completed medication cart audits to look for expired medications.

Telephone interview with the Nurse Case Manager at Resident #2's PCP's office on 09/30/21 at 12:37pm revealed:
-Resident #2 was ordered fluticasone for allergies.
-The PCP did not know Resident #2's fluticasone

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was not being administered as ordered.
-Resident #2's fluticasone should have been administered as ordered by his PCP.
-Resident #2 needed fluticasone to maintain control of his allergies.

Refer to interview with the Administrator on 09/30/21 at 2:30pm.

b. Review of Resident #2's current FL2 dated 04/30/21 revealed there was an order for lidocaine patches (used to treat pain) 5% apply 2 patches to skin daily for 12 hours then remove.

Review of Resident #2's medication administration record (MAR) for September 2021 revealed:
-There was an entry for lidocaine patches 5% apply 2 patches to skin daily for 12 hours then remove and scheduled for application at 8:00am and removal at 8:00pm.
-There was documentation 2 patches had been applied at 8:00am and removed at 8:00pm from 09/01/21 to 09/30/21.

Observation of Resident #2's medications on hand on 09/30/21 at 9:50am revealed there was a box of lidocaine patches 5% dispensed to the facility on 06/04/21 with a quantity of 30 and 29 patches were remaining.

Observation of Resident #2's medications on hand on 09/30/21 at 2:39pm revealed:
-There was a second box of lidocaine patches 5% dispensed to the facility on 06/01/21 with a quantity of 30 and 29 were remaining.
-There were 2 unopened boxes of lidocaine patches 5% dispensed to the facility on 02/11/21 with a quantity of 30 in each.
-There was an unopened box of lidocaine

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{C 330}	Continued From page 11 patches 5% dispensed to the facility on 09/21/20 with a quantity of 30. Telephone interview with a representative at Resident #2's contracted pharmacy on 09/30/21 at 3:26pm revealed: -Resident #2 had a current order for lidocaine patches 5% 2 patches to skin twice daily for 12 hours then remove for 12 hours. Apply to area of back pain. -Lidocaine patches 5% had been dispensed to the facility on 09/21/20, 02/11/21, and on 06/04/21 with a quantity of 60 each time. -Resident #2's lidocaine patches should last 30 days if administered as directed. -Lidocaine patches were not automatically sent to the facility; they had to be requested by staff. Interview with Resident #2 on 09/30/21 at 2:18pm revealed: -Lidocaine patches were applied to his back for pain. -He had a lot of pain in his back. -The SIC had not applied lidocaine patches daily to his skin on 09/30/21 or offered to apply the patches. -Staff did not apply the lidocaine patches to his skin daily and he last had one on 2 weeks ago. -If he wanted the lidocaine patches, he had to ask staff to apply the patches. -The lidocaine patches helped the pain in his back. Interview with a Supervisor-in-Charge (SIC) on 09/30/21 at 9:50am revealed: -She did not apply Resident #2's lidocaine patches daily, and she did not apply them this morning, 09/30/21. -She last applied Resident #2's lidocaine patches on last Wednesday, 09/22/21.	{C 330}		

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{C 330}	Continued From page 12 -She knew Resident #2's lidocaine patches should have been applied daily, but she did not know why she had not applied them -"He hasn't said a word about wanting the patches." -She did not know why she documented Resident #2's lidocaine patches had been applied daily. Telephone interview with the Nurse Case Manager at Resident #2's primary care physician's (PCP) office on 09/30/21 at 12:37pm revealed: -Resident #2 was ordered lidocaine patches for pain in his back. -The PCP did not know Resident #2's lidocaine patches were not being applied as ordered. -Resident #2's lidocaine patches should have been applied as ordered by his PCP. -Resident #2 needed the lidocaine patches to maintain control of his back pain. Refer to interview with the Administrator on 09/30/21 at 2:30pm. c. Review of Resident #2's current FL2 dated 04/30/21 revealed there was an order for nicotine patches (used to treat nicotine addiction) 7mg apply daily and remove old patch. Review of Resident #2's medication administration record (MAR) for September 2021 revealed: -There was an entry for nicotine patches 7mg apply 1 patch apply daily and remove old patch scheduled for application at 8:00am. -There was documentation the nicotine patch had been applied daily at 8:00am from 09/01/21 to 09/30/21. Observation of Resident #2's medications on	{C 330}		

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{C 330}	Continued From page 13 hand on 09/30/21 at 9:50am revealed: -There was an unopened box of nicotine patches 14mg dispensed from the pharmacy on 06/04/21 with a quantity of 14 and there were 9 patches remaining. -There were 2 unopened boxes of nicotine patches 7mg dispensed from the pharmacy on 09/08/21 with a quantity of 14 patches in each box. Telephone interview with a representative at Resident #2's contracted pharmacy on 09/30/21 at 3:26pm revealed: -Resident #2 had a current order for nicotine patches 7mg with instructions to: apply 1 patch to skin when you wake up and remove the old patch. Peel the back off the patch and put it on clean and dry. Start the 7mg patch after you have finished the 14 mg patch. -Resident #2's nicotine patches 7mg were dispensed from the pharmacy on 07/23/21 and on 09/08/21 with a 28-day supply on each date. -Nicotine patches 14mg were dispensed from the pharmacy on 02/01/21 and 06/04/21 with a 28-day supply on each date. -Each box of nicotine patches should have lasted 14 days (2 boxes for a 28-day supply) if administered as directed. - Nicotine patches were not automatically sent to the facility and refill of the nicotine patches had to be requested by staff. Interview with Resident #2 on 09/30/21 at 2:18pm revealed: -He had nicotine patches to help him stop smoking. -He continued to smoke, but not every day. -Staff last applied a nicotine patch about 2 weeks ago and he did not have a nicotine patch on today.	{C 330}		

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{C 330}	Continued From page 14 -The nicotine patch was not applied daily by staff; he had to ask for the nicotine patch when staff applied it. Interview with a Supervisor-in-Charge (SIC) on 9/30/21 at 9:50am revealed: -She did not apply a nicotine patch on Resident #2 today, 09/30/21, because he did not ask for one. -Resident #2 "normally" asked for the nicotine patch when he wanted it applied. -She knew the nicotine patch should be applied to Resident #2 daily, but she did not apply them daily. -She "normally" applied the nicotine patch about every other day. -She last applied the nicotine patch on last Wednesday, 09/22/21. Telephone interview with the Nurse Case Manager at Resident #2's primary care physician's (PCP) office on 09/30/21 at 12:37pm revealed: -Resident #2 was ordered nicotine patches to help him to stop smoking. -The PCP did not know Resident #2's nicotine patches were not being applied as ordered. -Resident #2's nicotine patches should have been applied as ordered by his PCP. -Resident #2 needed the nicotine patches to maintain control of his cravings for nicotine. Refer to interview with the Administrator on 09/30/21 at 2:30pm. _____ Interview with the Administrator on 09/30/21 at 2:30pm revealed: -She did not know Resident #2's medications were not being administered daily as ordered. -She did not know some of Resident #2's	{C 330}		

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{C 330}	Continued From page 15 medications on hand for administration were expired. -MAs were responsible for administering medications and reordering medications. -No one completed a cart audit to ensure medication was available and not expired. -She expected medications to be administered as ordered by the residents' PCP. _____ The facility failed to administer medications as order to 1 of 3 sampled residents (#2) who was not administered fluticasone daily which placed the resident at increased risk for allergy symptoms; not administered a lidocaine patch daily which caused increased pain; not administered a nicotine patch daily which caused the resident to continue to smoke. This failure was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/21 for this violation.	{C 330}		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	{C 342}		

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{C 342}	Continued From page 16	{C 342}		

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 2 of 3 sampled residents (Resident #2 and #3).

The findings are:

1. Review of Resident #2's current FL2 dated 04/30/21 revealed diagnoses included schizoaffective disorder bipolar type and Crohn's disease.

a. Review of Resident #2's current FL2 dated 04/30/21 revealed there was an order for fluticasone (used to treat rhinitis) 50mg nasal spray 1 spray into each nostril twice daily.

Review of Resident #2's MAR for September 2021 revealed:
-There was an entry for fluticasone 50mg nasal spray 2 spray into each nostril twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation fluticasone had been administered at 8:00am and 8:00pm from

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{C 342}	Continued From page 17 09/01/21 to 09/29/21 and the 8:00am dose was documented as administered on 09/30/21. Observation of Resident #2's medications on hand on 09/30/21 at 10:14pm revealed: -There was 1 bottle of fluticasone on hand. -There were instructions to instill 1 spray into the nostril 2 times daily with a maximum of 2 sprays in each nostril daily for allergies. -The bottle was dispensed on 09/09/19 and there was documentation to discard after 09/09/20. -There was more than half the medication remaining in the bottle. Observation of Resident #2's medication on hand 09/30/21 at 1:14pm revealed: -There was another bottle of fluticasone on hand. -There were instructions to instill 1 spray into the nostril 2 times daily with a maximum of 2 sprays in each nostril daily for allergies. -The second bottle of fluticasone was dispensed on 09/21/20 and there was documentation to discard after 09/21/21. -There was more than half the medication remaining in the bottle. Telephone interview with a representative at Resident #3's contracted pharmacy on 07/28/21 at 12:59pm revealed: -Resident #3's fluticasone was last filled and dispensed on 09/21/20. -Resident #3's fluticasone should last 30 days if administered as directed. -Fluticasone was not automatically dispensed to the facility. -Fluticasone had to be requested by staff before it was dispensed to the facility. Interview with Resident #2 on 09/30/21 at 2:18pm revealed:	{C 342}		

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{C 342}	Continued From page 18 -He suffered from allergies and he experienced nasal congestion. -He was administered fluticasone on 09/29/21 and on 09/28/21, but he could not remember when fluticasone was administered last prior to 09/28/21. -He was not administered fluticasone on today, 09/30/21, and he did not receive the medication daily. Interview with the Supervisor-in-Charge (SIC) on 09/30/21 at 9:50am revealed: -Resident #2 was to be administered fluticasone 1 spray in each nostril daily. -She transcribed the dosage incorrectly on the MAR. -She did not administered fluticasone to Resident #2 daily. -Last Wednesday, 09/22/21, was the last time she administered Resident #2's fluticasone. -She did not know why she had documented Resident #2's fluticasone as administered when she had not administered it. Refer to second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with a second SIC on 09/30/21 at 4:03pm. Refer to interview with the Administrator on 09/30/21 at 4:01pm. b. Review of Resident #2's current FL2 dated 04/30/21 revealed there was an order for lidocaine patches (used to treat pain) 5% apply 2 patches to skin daily for 12 hours then remove. Review of Resident #2's MAR for September 2021 revealed:	{C 342}		

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{C 342}	Continued From page 19 -There was an entry for lidocaine patches 5% apply 2 patches to skin daily for 12 hours then remove scheduled for application at 8:00am and removal at 8:00pm. -There was documentation 2 patches had been applied at 8:00am and removed 8:00pm from 09/01/21 to 09/29/21 and documentation the lidocaine patches were applied on 09/30/21 at 8:00am. Observation of Resident #2's medications on hand on 09/30/21 at 9:50am revealed there was a box of lidocaine patches 5% dispensed to the facility on 06/04/21 with a quantity of 30 and 29 patches were remaining. Observation of Resident #2's medications on hand on 09/30/21 at 2:39pm revealed: -There was a second box of lidocaine patches 5% dispensed to the facility on 06/01/21 with a quantity of 30 and 29 were remaining. -There were 2 unopened boxes of lidocaine patches 5% dispensed to the facility on 02/11/21 with a quantity of 30 in each. -There was an unopened box of lidocaine patches 5% dispensed to the facility on 09/21/20 with a quantity of 30. Telephone interview with a representative at Resident #2's contracted pharmacy on 09/30/21 at 3:26pm revealed: -Resident #3 had a current order for lidocaine patches 5% 2 patches to skin twice daily for 12 hours then remove for 12 hours. Apply to area of back pain. -Lidocaine patches 5% had been dispensed to the facility on 09/21/20, 02/11/21, and on 06/04/21 with a quantity of 60 each time. -Resident #2's lidocaine patches should last 30 days if administered as directed.	{C 342}		

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{C 342}	Continued From page 20 -Resident #2's Lidocaine patches were not automatically sent to the facility; they had to be requested by staff. Interview with Resident #2 on 09/30/21 at 2:18pm revealed: -Lidocaine patches were applied to his back for pain. -He had a lot of pain in his back. -The SIC had not applied lidocaine patches to his skin on 09/30/21. -Staff did not apply the lidocaine patches to his skin daily and he last had one applied 2 weeks ago. Interview with a Supervisor-in-Charge (SIC) on 09/30/21 at 9:50am revealed: -She did not apply Resident #2's lidocaine patches daily, and she did not apply them this morning, 09/30/21. -She last applied Resident #3's lidocaine patches on last Wednesday, 09/22/21. -She knew Resident #2's lidocaine patches should have been applied daily, but she did not know why she had not applied them -She did not know why she documented Resident #2's lidocaine patches had been applied daily. Refer to second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with a second SIC on 09/30/21 at 4:03pm. Refer to interview with the Administrator on 09/30/21 at 4:01pm. c. Review of Resident #2's current FL2 dated 04/30/21 revealed there was an order for nicotine patches (used to treat nicotine addiction) 7mg	{C 342}		

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{C 342}	Continued From page 21 apply daily and remove old patch. Review of Resident #2's MAR for September 2021 revealed: -There was an entry for nicotine patches 7mg apply 1 patch apply daily and remove old patch scheduled for application at 8:00am. -There was documentation the nicotine patch had been applied daily at 8:00am from 09/01/21 to 09/30/21. Observation of Resident #2's medications on hand on 09/30/21 at 9:50am revealed: -There was an unopened box of nicotine patches 14mg dispensed from the pharmacy on 06/04/21 with a quantity of 14 and there 9 patches remaining. -There were 2 unopened boxes of nicotine patches 7mg dispensed from the pharmacy on 09/08/21 with a quantity of 14 patches in each box. Telephone interview with a representative at Resident #2's contracted pharmacy on 09/30/21 at 3:26pm revealed: -Resident #2 had a current order for nicotine patches 7mg with instructions as follows: apply 1 patch to skin when you wake up and remove the old patch. Peel the back off the patch and put it on clean and dry. Start the 7mg patch after you have finished the 14 mg patch. -Resident #2's nicotine patches 7mg were dispensed from the pharmacy on 07/23/21 and on 09/08/21 with a 28-day supply on each date. -Nicotine patches 14mg were dispensed from the pharmacy on 02/01/21 and 06/04/21 with a 28-day supply on each date. -Each box of nicotine patches should have lasted 14 days (2 boxes for a 28-day supply) if administered as directed.	{C 342}		

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{C 342}	Continued From page 22 -Nicotine patches were not automatically sent to the facility and refill of the nicotine patches had to be requested by staff. Interview with Resident #2 on 09/30/21 at 2:18pm revealed: -He had nicotine patches to help him stop smoking. -Staff last applied a nicotine patch about 2 weeks ago and he did not have a nicotine patch on today. -Staff did not apply the nicotine patch every day. Interview with a Supervisor-in-Charge (SIC) on 9/30/21 at 9:50am revealed: -She did not apply a nicotine patch on Resident #2 today, 09/30/21. -She knew the nicotine patch should be applied to Resident #2 daily, but she did not apply them daily. -She "normally" applied the nicotine patch about every other day. -She last applied the nicotine patch on last Wednesday, 09/22/21. Refer to a second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with a second SIC on 09/30/21 at 4:03pm. Refer to interview with the Administrator on 09/30/21 at 4:01pm. 2. Review of Resident #3's current FL2 revealed diagnoses included degenerative joint disease, hypertension, and enlarged prostrate. a. Telephone interview with a representative at Resident #3's contracted pharmacy on 09/30/21	{C 342}		

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{C 342}	Continued From page 23 at 3:26pm revealed: -Resident #3 had a current order dated 09/24/21 for lidocaine 5% patches apply 1 patch to skin every day; apply once daily for up to 12 hours (12 hours on then remove for 12 hours). -lidocaine 5% patches were dispensed by the pharmacy on 09/24/21. Review of Resident #3's medication administration record (MAR) for September 2021 revealed: -There was an entry for lidocaine 5% patch apply to skin every day; apply once daily for up to 12 hours (12 hours on then remove for 12 hours scheduled to be applied at 8:00am and removed at 8:00pm. -There was no documentation the lidocaine 5% patch had been applied or removed from 09/24/21 through 09/30/21. -There was no documentation on the back of the MAR regarding lidocaine 5% patches. Observation of Resident #3's medications on hand on 09/30/21 at 10:58am revealed: -There was 1 unopened box of lidocaine 5% patches dispensed by the pharmacy on 09/24/21 with a quantity of 30 patches. -The directions were to apply 1 patch to skin every day; apply once daily for up to 12 hours (12 hours on then remove for 12 hours). Interview with Resident #3 on 09/30/21 at 2:11pm revealed: -He had an order for the lidocaine patches because of pain. -He refused the lidocaine patches and had not worn them because he did not feel that they worked for him. Interview with a Supervisor-in-Charge (SIC) on	{C 342}		

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{C 342}	Continued From page 24 9/30/21 at 11:00am revealed: -Resident #3's lidocaine 5% patches had not been applied since they had been dispensed by the pharmacy on 09/24/21 because Resident #3 refused them. -She did not know why she did not document Resident #3's lidocaine patches were not administered on the MAR and the reason why they were not administered on the back of the MAR. Refer to a second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with a second SIC on 09/30/21 at 4:03pm. Refer to interview with the Administrator on 09/30/21 at 4:01pm. b. Telephone interview with Resident #3's pharmacy on 09/30/21 at 3:26pm revealed: -There was a current order dated 09/10/21 for menthol/m-salicylate 10-15% topical cream apply small amount three times a day for pain. -Menthol/m-salicylate was dispensed by the pharmacy on 09/10/21. Review of Resident #3's medication administration record (MAR) for September 2021 revealed: -There was an entry for menthol/m-salicylate 10-15% topical cream apply small amount three times a day for pain scheduled for administration at 8:00am. 2:00pm, and 8:00pm. -There was no documentation menthol/m-salicylate 10-15% had been applied from 09/26/21 at 8:00am through 09/30/21 at 8:00pm. -There was no documentation on the back of the	{C 342}		

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{C 342}	Continued From page 25 MAR why menthol/m-salicylate 10-15% had not been applied. Observation of Resident #3's medications on hand on 09/30/21 at 10:58am revealed: -There was a boxed tube of menthol/m-salicylate 10-15% cream dispensed by the pharmacy on 09/10/21. -The directions were to apply a small amount three times a day for pain. Interview with Resident #3 on 09/30/21 at 2:11pm revealed: -He had an order for pain cream, but he refused to have the cream applied by staff. -He refused the cream because he did not feel that the cream worked for him. Interview with a Supervisor-in-Charge (SIC) on 9/30/21 at 11:00am revealed: -Resident #3 had a pain cream that was supposed to be applied daily, but he refused to have the medication applied. -She had not documented Resident #3's pain cream was not administered from 09/25/21 through 09/30/21 on Resident #3's MAR or the reason the medication was not administered on the back of the MAR, and she did not know why she did not document. Refer to a second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with a second SIC on 09/30/21 at 4:03pm. Refer to interview with the Administrator on 09/30/21 at 4:01pm. c. Telephone interview with Resident #3's	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032062	A. BUILDING: _____ B. WING _____	R-C 09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 342}	Continued From page 26	{C 342}		

pharmacy on 09/30/21 at 3:26pm revealed:
-There was a current order dated 09/10/21 for capsaicin 0.025% apply small amount topically three times a day.
-Capsaicin was dispensed by the pharmacy on 09/10/21.

Review of Resident #3's medication administration record (MAR) for September 2021 revealed:
-There was an entry for capsaicin 0.025% apply small amount topically three times a day scheduled for administration at 8:00am. 2:00pm, and 8:00pm.
-There was no documentation capsaicin had been applied from 09/28/21 at 8:00am through 09/30/21 at 8:00am.
-There was no documentation on the back of the MAR why capsaicin had not been applied from 09/28/21 through 09/30/21.

Observation of Resident #3's medications on hand on 09/30/21 at 10:58am revealed:
-There was a boxed tube of capsaicin 0.025% cream dispensed by the pharmacy on 09/10/21.
-The directions were to apply small amount three times a day.

Interview with Resident #3 on 09/30/21 at 2:11pm revealed:
-He had an order for pain creams, but he refused to have the cream applied by staff.
-He refused the cream because he did not feel that they worked for him.

Interview with a Supervisor-in-Charge (SIC) on 9/30/21 at 11:00am revealed:
-Resident #3 had a pain creams that were supposed to be applied daily, but he refused to have the medication applied.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 342}	Continued From page 27 -She had not documented Resident #3's capsaicin was not administered from 09/28/21 through 09/30/21 on Resident #3's MAR or the reason the medication was not administered on the back of the MAR, and she did not know why she did not document. Refer to a second interview with a SIC on 09/30/21 at 3:01pm. Refer to interview with a second SIC on 09/30/21 at 4:03pm. Refer to interview with the Administrator on 09/30/21 at 4:01pm. _____ A second interview with a SIC on 09/30/21 at 3:01pm revealed: -When medication was not administered to a resident, the SIC was supposed to write their initials on the MAR and circle the initials. -On the back of the MAR, the SIC was supposed to write the reason why the medication was not administered. -She had not documented the MAR accurately because she must have gotten busy with something else. Interview with a second SIC on 09/30/21 at 4:30pm revealed: -He was responsible for reviewing the residents' MARs and review them weekly. -He had not noticed any errors with documentation on the MAR. Interview with the Administrator on 09/30/21 at 4:01pm revealed: -The second MA was responsible for reviewing the MARs monthly. -She did not know medications had been	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 342}	Continued From page 28 documented as administered when they were not administered, there was no documentation on MARs of a reason a medication was administered or not, or there was no documentation on the back of the MAR of the reason a medication was not administered. -She expected SICs to document resident MARs correctly.	{C 342}		
{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 federal and state laws and rules and regulations related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (Resident #2) related to an allergy medication, a pain medication, and a chemical dependence patch. [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Unabated Type B Violation)].	{C 912}		