STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL039011	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS FAMILY CARE HOME	408 MIMOSA STREET OXFORD, NC 27565

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on September 14, 2022.	C 000		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2, and #3) had an updated care plan annually. The findings are:	C 231		

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C 231	Continued From page 1 1. Review of Resident #1's current FL-2 dated 11/15/21 revealed diagnoses included seizure disorder and transient ischemic attack. Review of Resident #1's most current care plan revealed: -Resident #1's care plan was completed on 04/28/21. -The Primary Care Provider (PCP) signed the care plan on 04/28/21. -There was not another care plan completed since 04/28/21. Refer to interview with the Administrator on 09/14/22 at 2:36pm. 2. Review of Resident #2's current FL-2 dated 06/24/22 revealed diagnoses included mild mental retardation, schizophrenia, anxiety, depression, gastro-esophageal reflux disorder, type 2 diabetes mellitus, hypertension, hyperlipidemia and asthma. Review of Resident #2's most current care plan revealed: -Resident #2's care plan was completed on 04/20/21. -Resident #2's Primary Care Provider (PCP) signed the care plan on 04/21/21. -There was not another care plan completed since 04/20/21. Refer to interview with the Administrator on 09/14/22 at 2:36pm. 3. Review of Resident #3's current FL-2 dated 10/01/21 revealed diagnoses included diabetes mellitus, hypertension, hyperlipidemia, schizophrenia, glaucoma, gout, osteoarthritis,	C 231		

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C 231	Continued From page 2 vitamin D deficiency and overactive bladder. Review of Resident #3's most current care plan revealed: -Resident #3's care plan was completed on 04/20/21. -Resident #3's Primary Care Provider (PCP) signed the care plan on 04/20/21. -There was not another care plan completed since 04/20/21. Refer to interview with the Administrator on 09/14/22 at 2:36pm. Interview with the Administrator on 09/14/22 at 2:36pm revealed: -She had not completed new care plans for any of the residents since April 2021. -She knew she was supposed to update residents' care plans annually. -She forgot to complete the annual care plans in April 2021. -She was responsible for ensuring resident care plans were updated annually and signed by Primary Care Provider (PCP).	C 231		
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.	C 330		

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C 330	Continued From page 3 This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medication were administered as ordered for 1 of 3 sampled residents related to a medication used to manage blood sugar (#1). The findings are: Review of Resident #1's current FL-2 dated 11/15/21 revealed diagnoses included seizure disorder and transient ischemic attack. Review of Resident #1's previous FL-2 dated 11/15/20 revealed a diagnosis of diabetes mellitus. Review of Resident #1's signed physician's orders dated 06/15/22 revealed there was an order for Humalog (used to treat elevated blood glucose) 4 units three times daily. Review of Resident #1's August 2022 electronic medication administration record (eMAR) revealed: -There was no entry for Humalog 4 units three times daily. -There was no documentation that Humalog 4 units had been administered three times daily from 08/01/22 to 08/31/22. Review of Resident #1's September 2022 eMAR from 09/01/22 to 09/13/22 revealed: -There was no entry for Humalog 4 units three times daily. -There was no documentation that Humalog 4 units had been administered three times daily from 09/01/22 to 09/13/22.	C 330		

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C 330	Continued From page 4 Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/14/22 at 12:12pm revealed: -The pharmacy had an order for Humalog 4 units three times daily for Resident #1 dated 06/06/22. -The pharmacy dispensed 1 box of 5 pens on 06/06/22 and 09/13/22. -The pharmacy had not received an order to discontinue Humalog 4 units three times daily. Observation of 8:00am medication pass on 09/14/22 at 9:28 revealed the MA administered Humalog 4 units to Resident #1. Interview with the MA/Administrator on 09/14/22 at 1:45 revealed: -She did not add Humalog 4units to the August 2022 and September 2022 eMARs. -Resident #1 had an order for Humalog SSI; she followed the SSI for administration of Humalog insulin. -She did not realize it was two different orders; she only administered the Humalog SSI based on the blood glucose reading. -She should have entered the Humalog 4 units on the eMAR as a scheduled medication and administered the medication as ordered. Attempted to interview Resident #1's Primary Care Provider (PCP) on 09/14/22 at 12:45pm.	C 330		
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	C 341		

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C 341	Continued From page 5 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 medications were not pre-charted on the medication administration record prior to administration of the medications for 3 of 3 residents (#1, #2 and #3) observed during the 8:00am morning medication pass on 09/14/22. The findings are: Observation of the 8:00am medication pass on 09/14/22 revealed: -The Administrator prepared medications for administration to Resident #1 and administered the medications at 9:08am. -The Administrator did not sign Resident #1's medication administration record (MAR) after administration of medication. -The Administrator prepared medications for administration to Resident #2 and administered the medications at 9:12am. -The Administrator did not sign Resident #2's MAR after administration of medication. -The Administrator prepared medications for administration to Resident #3 and administered the medications at 9:14am. -The Administrator did not sign Resident #2's MAR after the administration of medication. 1. Review of Resident #1's current FL-2 dated	C 341		

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11/15/21 revealed:
-Diagnoses included seizure disorder and transient ischemic attack.
-There was an order for amlodipine (used to treat elevated blood pressure) 10mg daily.
-There was an order for aspirin (used to prevent a heart attack and stroke) 81mg daily.
-There was an order for Cozaar (used to lower blood pressure) 100mg daily.
-There was an order for hydrochlorothiazide (used to treat blood pressure) 25mg daily.
-There was an order for Jardiance (used to maintain blood sugar) 10mg daily.
-There was an order for Lipitor (use to treat elevated cholesterol) 40mg daily.
-There was an order for metformin (used to manage blood sugar) 1000mg daily.
-There was an order for metoprolol (used to treat elevated blood pressure) 100mg daily.
-There was an order for Plavix (used to prevent the formation of blood clots) 75mg daily.
-There was an order for clonidine (used to treat elevated blood pressure) 0.1mg twice daily.
-There was an order for Tegretol (used to treat seizures) 200mg twice daily.
-There was an order for Vascepa (used to lower the risk of heart problems related to elevated cholesterol levels) 1gm twice daily.

Review of Resident #1's signed physician order dated 02/03/22 revealed an order for Proscar (used to treat symptoms with an enlarged prostate) 5mg daily.

Review of Resident #1's September 2022 medication administration record (MAR) on 09/14/22 at 7:40am revealed:
-There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of

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amlodipine had been administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of aspirin had been administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for Cozaar 100mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Cozaar had been administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for hydrochlorothiazide 25mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of hydrochlorothiazide had been administered on 09/14/22 prior to MAR the observation of the 8:00am medication pass.
-There was an entry for Jardiance 10mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Jardiance had been administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for Lipitor 40mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Lipitor had been administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for metformin 1000mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of metformin had been administered on 09/14/22 prior to the observation of the 8:00am medication pass.

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C 341	Continued From page 8 -There was an entry for metoprolol 100mg daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of metoprolol had been administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for Plavix 75mg daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of Plavix was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for Proscar 5mg daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of Proscar was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for clonidine 0.1mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation the 8:00am dose of clonidine was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for Tegretol 200mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation the 8:00am dose of Tegretol was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for Vascepa 1gm twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation the 8:00am dose of Vascepa 1gm was administered on 09/14/22 prior to the observation of the 8:00am medication pass. Refer to the interview with the Administrator on 09/14/22 at 1:40pm. 2. Review of Resident #2's current FL-2 dated	C 341		

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C 341	Continued From page 9 06/24/22 revealed: -Diagnoses included mild mental retardation, schizophrenia, anxiety, depression, gastro-esophageal reflux disorder, type 2 diabetes mellitus, hypertension, hyperlipidemia and asthma. -There was an order for aspirin (used to prevent a heart attack and stroke) 81mg daily. -There was an order for Protonix (used to treat symptoms of heartburn) 40mg daily. -There was an order for vitamin D3 (used as a supplement) 1000iu 3 tablets daily. -There was an order for metformin (used to treat high blood sugar levels) 500mg twice daily. Review of Resident #2's September 2022 medication administration record (MAR) on 09/14/22 at 8:34am revealed: -There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of aspirin was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for Protonix 40mg daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of Protonix was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for vitamin D3 1000iu three tablets daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of vitamin D3 was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for metformin 500mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation the 8:00am dose of metformin was administered on 09/14/22 prior to the observation of the 8:00am medication pass.	C 341		

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C 341	Continued From page 10 Refer to the interview with the Administrator on 09/14/22 at 1:40pm. 3. Review of Resident #3's current FL-2 dated 10/01/21 revealed: -Diagnoses included diabetes mellitus, hypertension, hyperlipidemia, schizophrenia, glaucoma, gout, osteoarthritis, vitamin D deficiency and overactive bladder. -There was an order for Cozaar (used to treat elevated blood pressure) 100mg daily. -There was an order for aspirin (used to prevent a heart attack and stroke) 81mg daily. -There was an order for Imdur (used to prevent chest pain) 30mg daily. -There was an order for Lasix (used to reduce fluid in the body) 40mg daily. -There was an order for metformin (used to lower blood sugar) 500mg daily. -There was an order for metoprolol (used to lower blood pressure) 25mg daily. -There was an order for Norvasc (used to lower blood pressure) 10mg daily. -There was an order for Plavix (used to prevent blood clots) 75mg daily. -There was an order for Vesicare (used to treat overactive bladder) 5mg daily. Review of Resident #3's September 2022 medication administration record (MAR) on 09/14/22 at 8:51am revealed: -There was an entry for Cozaar 100mg daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of Cozaar was administered on 09/14/22 prior to the observation of the 8:00am medication pass. -There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation the 8:00am dose of	C 341		

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aspirin was administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for Imdur 30mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Imdur was administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for Lasix 40mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Lasix was administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for metformin 500mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of metformin was administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for metoprolol 25mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of metoprolol was administered on 09/14/822 prior to the observation of the 8:00am medication pass.
-There was an entry for Norvasc 10mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Norvasc was administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for Plavix 75mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Plavix was administered on 09/14/22 prior to the observation of the 8:00am medication pass.
-There was an entry for Vesicare 5mg daily with a scheduled administration time of 8:00am.
-There was documentation the 8:00am dose of Vesicare was administered on 09/14/22 prior to the observation of the 8:00am medication pass.

Refer to the interview with the Administrator on

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C 341	Continued From page 12 09/14/22 at 1:40pm. _____ Interview with the Administrator on 09/14/22 at 1:40pm revealed: -When she administered medications yesterday, 09/13/22, she signed the MAR for today, 09/14/22. -When she administered medications today, 09/14/22, she knew the MAR was already signed. -She realized yesterday, that she was a day ahead on the MAR documentation. -She did not pre-chart on the MARS; she pre-charted on 09/14/22 by accident. -She was aware that MAR documentation should be after the administration of medications.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a	C 342		

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C 342	Continued From page 13	C 342		

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, record reviews and interviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 2 of 3 sampled residents related to a medication used for depression (#2) and a medication for elevated cholesterol (#3).

The findings are:

1. Review of Resident #2's current FL-2 dated 06/24/22 revealed diagnoses included schizophrenia and depression.

Review of Resident #2's physician's order dated 08/24/22 revealed there was an order for Caplyta (used to treat depression) 42 mg daily.

Review of Resident #2's August 2022 medication administration record (MAR) from 08/24/22 to 08/31/22 revealed:
-There was no entry for Caplyta 42mg to be administered.
-There was no documentation that Caplyta was administered from 08/24/22 to 08/31/22

Review of Resident #2's September 2022 medication administration record (MAR) from 09/01/13 to 09/14/22 revealed:
-There was no entry for Caplyta 42mg to be administered.
-There was no documentation that Caplyta was administered from 09/01/22 to 09/14/22

Observation of Resident #2's medication on hand on 09/14/22 at 11:14am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL039011	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS FAMILY CARE HOME	408 MIMOSA STREET OXFORD, NC 27565

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C 342	Continued From page 14 -There was a bubble pack of Caplyta 42mg one capsule daily with a dispensed date of 08/25/22, available for administration. -There were 30 Caplyta capsules dispensed on 08/25/22; there were 14 tablets remaining in the bubble pack. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/14/22 at 12:12pm revealed: -The pharmacy had an order for Caplyta 42mg one capsule daily for Resident #2 dated 08/24/22. -The pharmacy dispensed 30 capsules of Caplyta on 08/25/22. -The facility staff should write the new medication on the August 2022 MAR. -The medication was entered in the computer system but did not print on the September 2022 MAR because the MARs for September had been printed and shipped to the facility. -The medication would show on the October MAR when printed. Interview with the Administrator on 09/14/22 at 1:40pm revealed: -She had administered Caplyta 42mg to Resident #2 each morning. -She knew Resident #2 received a new order for Caplyta; she knew to administer the medication. -She followed the directions on the blister pack when administering the medication. -She did not refer to the MAR because she administered all medications to Resident #2; she was the only MA and she knew the medications Resident #2 was to be administered. -She thought she had written the entry for Caplyta on the August 2022 and September 2022 MARs. -She did not realize she did not document Caplyta was administered on the August 2022 and September 2022 MARs.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL039011	A. BUILDING: _____ B. WING _____	09/14/2022

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C 342	Continued From page 15 -She was responsible for entering the new medication on the August 2022 and September 2022 MARs -She administered the medication to Resident #2 even though she did not document the medication was administered. -She should refer to the MARs when administering medications to ensure all medications were documented correctly. 2. Review of Resident #3's current FL-2 dated 10/01/21 revealed: -Diagnosis included hyperlipidemia. -There was an order for atorvastatin (used to treat cholesterol) 10mg daily. Review of Resident #3's July 2022 medication administration record (MAR) revealed: -There was an entry for atorvastatin 10mg daily with a scheduled administration time of 8:00am. -There was documentation atorvastatin was administered daily from 07/01/22 to 07/31/22. Review of Resident #3's August 2022 medication administration record (MAR) revealed: -There was an entry for atorvastatin 10mg daily with a scheduled administration time of 8:00am. -There was documentation atorvastatin was administered daily from 08/01/22 to 08/31/22. Review of Resident #3's September 2022 medication administration record (MAR) from 09/01/13 to 09/14/22 revealed: -There was an entry for atorvastatin 10mg daily with a scheduled administration time of 8:00am. -There was documentation atorvastatin was administered from 09/01/22 to 09/14/22 at 8:00am. Observation of Resident #3's medication on hand	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 16 on 09/14/22 at 11:16am revealed there was no atorvastatin available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/14/22 at 12:12pm revealed: -The pharmacy had an order for atorvastatin 10mg daily for Resident #3. -The pharmacy dispensed 30 atorvastatin tablets (a 30-day supply) on 02/02/22, 03/02/22 and 04/05/22. -The facility staff had not requested a refill for atorvastatin 10mg since 04/05/22. -The facility was not on cycle fill; all medications had to be re-ordered by the facility when needed. -The pharmacy received an order dated 04/08/22 to continue atorvastatin 10mg daily. Interview with the Administrator on 09/14/22 at 1:45pm revealed: -She did not know why atorvastatin was not available for administered. -She did not know why atorvastatin had not been ordered since 04/05/22. -She was responsible for administering and ordering all medications for the residents. -It was an oversight on her part that the atorvastatin was not in the facility to be administered. -She did not use Resident #3's MAR when she prepared the medication today, 09/14/22. -She should have used Resident #3's MAR and compared the medications on hand with the medication entries on the MAR; she would have caught the mistake. -She documented on the MAR inaccurately that atorvastatin was administered when it was not.	C 342		

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C 346	Continued From page 17	C 346		
C 346	10A NCAC 13G .1004(n) Medication Administration 10A NCAC 13G .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interview, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who performed a fingerstick blood sugar (FSBS) and insulin injection with ungloved, bare hands; and failed to wash her hands with soap and water before FSBS check and before and after insulin administration. The findings are: Observation of the morning medication pass on 09/14/22 at 8:58am revealed: -The medication aide (MA) initiated preparing to check a fingerstick blood sugar (FSBS) by gathering a glucometer, a lancet, a glucose strip and an alcohol wipe. -The MA turned the glucometer on and placed the glucose strip in the meter. -The MA approached a resident, cleaned the fourth finger on the left hand, pricked the finger with the lancet and placed a drop of blood on the glucose strip. -The MA returned to the medication closet, returned the glucometer to resident's cubicle, proceeded to the kitchen sink and washed her hands. -The MA did not wash her hands prior to checking	C 346		

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 346	Continued From page 18 the FSBS. -The MA did not don gloves while obtaining the FSBS. Observation of the morning medication pass on 09/14/22 at 9:28am revealed: -The MA retrieved the resident's 2 insulin pens, 1 Humalog (a short-acting insulin used to manage blood sugar) and 1 Lantus (a long-acting insulin used to manage blood sugar), 2 pen needles and 2 alcohol wipes. -The MA placed a needle on the Lantus pen, prepared the insulin pen for injection and injected 4 units of Lantus into the resident's right arm. -The MA placed a needle on the Humalog pen, prepared the insulin pen for injection and injected 4 units of Humalog into the resident's left arm. -The MA realized she was to administer 5 units of Lantus to the resident; she retrieved a third pen needle placed the needle on the Lantus insulin pen, prepared the insulin pen for injection and injected 1 unit of Lantus into the resident's right arm. -The MA did not don gloves during the administration of the insulin to the resident. -The MA did not wash her hands before or after the administration of the insulin to the resident. Interview with the Administrator on 09/14/22 at 2:36am revealed: -She did not wear gloves when obtaining the FSBS or administration of the insulin. -She had boxes of gloves available to wear. -She did not have an excuse as to why she did not don gloves for the FSBS and the administration of the insulin. -She should have worn gloves during the FSBS and administration of the insulin to prevent contact with the resident's blood. -She thought she washed her hands after the	C 346		

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C 346	Continued From page 19 FSBS was checked. -She knew she should wash her hands before and after insulin injections; she forgot to wash her hands.	C 346		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
FCL039011	A. Building B. Wing	9/14/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIS FAMILY CARE HOME	408 MIMOSA STREET OXFORD, NC 27565

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix C0252 Reg. # 10A NCAC 13G .0903(a) LSC	Correction Completed 09/14/2022	ID Prefix C0367 Reg. # 10A NCAC 13G .1008(a) LSC	Correction Completed 09/14/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/8/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: YR4W12