

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER SINCERE MANOR FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 334 ZEB ROAD GIBSONVILLE, NC 27249		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 08/11/22 through 08/12/22.	C 000		
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 sampled residents (#1 and #2) regarding daily blood pressure (BP) checks and fingerstick blood sugar checks (FSBS) (#2) and weekly blood pressure (BP) checks (#1). The findings are: 1. Review of Resident #2's current FL2 inadvertently dated 11/20/22 (should have been dated 01/20/22 as clarified by Resident #2's Primary Care Provider/PCP) revealed: -Diagnoses included hypertension. -There was an order for blood pressure (BP) checks twice a day. Review of Resident #2's medication administration records (MARs) for June, July, and August 2022 revealed there was an entry for BP checks once a day, but there was not an entry for BP checks twice a day.	C 249	Upon receiving fl2 from doctor's office, I will ensure that the doctor office sends copy to pharmacy and myself. I will then call pharmacy to ensure receipt. If not received I will send myself. I will also implement monthly fl2, MAR, and medication checks to make sure all orders and date are correct and match what is set out by physician. Making sure the correct medication and documents are in the facility at all times and ensure that all staff is trained in recognizing and implementing. I will also ensure that staff is trained and certified in all LHPS and medication areas.	09/30/22 09/26/22 <i>KB</i>

Division of Health Service Regulation

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



TITLE

Administrator

(X6) DATE

9/21/2022

STATE FORM

6899

F0QK11

If continuation sheet 1 of 13

Reviewed and Acknowledged

Keisha Banks

10/03/22

Division of Health Service Regulation

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C 249	Continued From page 1 Telephone interview with the facility's contracted pharmacy on 08/11/22 at 2:17pm revealed: -Resident #2 had an order for blood pressure (BP) checks once daily. -The pharmacy had not received the FL2 inadvertently dated 11/20/22 (should have been dated 01/20/22 as clarified by Resident #2's PCP) with the order for BP checks twice a day. Interview with Resident #2 on 08/11/22 at 3:53pm revealed: -Staff did not check his BP every day. -Sometimes staff checked his BP once a daily and sometimes they did not. Telephone interview with a medical assistant at Resident #2's primary care provider's (PCP) office on 08/11/22 at 2:58pm revealed: -Resident #2 was seen by the PCP and an FL2 was completed for Resident #2 on 01/20/22. -The date of 11/20/22 was incorrect and was inadvertently written as the eleventh month. -She would have a nurse to call back to confirm the order for BP for Resident #2. Attempted telephone interview with Resident #2's PCP on 08/11/22 at 2:58pm was unsuccessful. Interview with the supervisor-in-charge (SIC) on 08/11/22 at 4:40pm revealed: -He did not know Resident #2 had an order from his PCP for BP checks twice a day. -He had been checking Resident #2's BP once a day and there was an entry for BP checks daily on Resident #2's MAR. -The Administrator was responsible for reviewing residents' orders, including FL2s, and sending them to the pharmacy.	C 249	On 8/18/22 FL2 form for resident #2 was updated with the correct date and provided to pharmacy and facility. BP was updated to being taken daily. Pharmacy also provided a blood sugar monitor for for diabetic testing for resident. Staff has been informed of update and has been trained on how to check FL2 for any and all updates. I will also implement monthly checks to make sure that all orders match the fl2, medications in facility, pharmacy records and what the resident is actually being given. There was also an LHPS performed on resident.	08/30/22 09/26/22 <i>KB</i>

Division of Health Service Regulation

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C 249	Continued From page 2 Interview with the Administrator on 08/12/22 at 9:05am revealed: -She reviewed Resident #1's FL2 inadvertently dated 11/20/22 (should have been dated 01/20/22), but she did not notice the order for BP checks twice a day. -Resident #1 was seen by his PCP in January 2022 and the FL2 should have been dated 01/20/22. -She thought she had sent Resident #1's FL2 to the pharmacy. -She contacted Resident #1's PCP in July 2022 to complete a new FL2 to update the date, but she did not ask about the order for BP checks twice daily. b. Review of Resident #2's current FL2 inadvertently dated 11/20/22 (should have been dated 01/20/22 as clarified by Resident #2's Primary Care Provider/PCP) revealed: -Diagnoses included type II diabetes mellitus. -There was an order for fingerstick blood sugar (FSBS) checks three times daily. Review of Resident #2's medication administration records (MAR) for June, July, and August 2022 revealed there was not an entry for FSBS checks three times daily. Telephone interview with the facility's contracted pharmacy on 08/11/22 at 2:17pm revealed: -The pharmacy did not have an order for FSBS checks 3 times daily for Resident #2. -The pharmacy had not received the FL2 dated inadvertently dated 11/20/22 (should have been dated 01/20/22) with the order for FSBS checks 3 times daily. Interview with Resident #2 on 08/11/22 at 3:53pm revealed:	C 249		

Division of Health Service Regulation

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C 249	Continued From page 3 -His primary care physician (PCP) had told him he was diabetic, but he did not know if he was or not. -He got FSBS checks when he went to his PCP's office, but he had never had FSBS checks at the facility. Telephone interview with a medical assistant at Resident #2's primary care provider's (PCP) office on 08/11/22 at 2:58pm revealed: -Resident #2 was seen by the PCP and an FL2 was completed for Resident #2 on 01/20/22. -The date of 11/20/22 was incorrect and was inadvertently written as the eleventh month. -She would have a nurse to call back to confirm the order for BP for Resident #2. Attempted telephone interview with Resident #2's PCP on 08/11/22 at 2:58pm was unsuccessful. Interview with the supervisor-in-charge (SIC) on 08/11/22 at 4:40pm revealed: -He did not know Resident #2 had an order for FSBS checks 3 times daily. -He had not completed FSBS checks for Resident #2. -FSBS checks were not on Resident #2's MAR. -The Administrator was responsible for reviewing residents' orders, including FL2s, and sending them to the pharmacy. Interview with the Administrator on 08/12/22 at 9:05am revealed: -She reviewed Resident #2's FL2 inadvertently dated 11/20/22 (should have been dated 01/20/22), but she did not notice the order for FSBS 3 times a day. -Resident #1 was seen by his PCP in January 2022 and the FL2 should have been dated 01/20/22.	C 249		

Division of Health Service Regulation

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C 249	Continued From page 4 -She thought she had sent Resident #2's FL2 to the pharmacy. -She contacted Resident #2's PCP in July 2022 to complete a new FL2 to update the date, but she did not ask about the order for FSBS checks 3 times daily. 2. Review of Resident #1's current FL2 dated 03/27/22 revealed: -Diagnoses included essential primary hypertension. -There was an order for blood pressure (BP) checks once a week. Review of Resident #1's medication administration records (MARs) for June, July, and August 2022 revealed there was not an entry for BS checks once a week. Telephone interview with the facility's contracted pharmacy on 08/11/22 at 2:17pm revealed: -The pharmacy did not have an order for Resident #1 for BP checks once a week. -The pharmacy had not received the FL2 dated 03/27/22 with the order for BP once a week. Interview with Resident #1 on 08/11/22 at 3:58am revealed staff did not check her blood pressure once a week. Telephone interview with a registered nurse from Resident #1's primary care physician's (PCP) office on 08/11/22 at 4:05pm revealed: -Resident #1 had a diagnosis of hypertension. -The PCP ordered BP checks once a week and requested staff to bring in BP readings during Resident #1's 3-month visits. -The weekly BP checks were ordered to gauge Resident #1's BP while in the facility and to determine if medication was needed.	C 249	Correct FL2 was sent to pharmacy by myself on 8/11/22. Resident's BP is now checked and recored weekly per orders by physician. Staff has been trained on taking BP, recording findings, and checking/reviewing FL2.	09/08/22 09/26/22 KB

Division of Health Service Regulation

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C 249	Continued From page 5 Interview with the supervisor-in-charge (SIC) on 08/11/22 at 4:40pm revealed: -He knew Resident #1 had a physician's order for BP checks weekly. -He had not completed BP checks weekly for Resident #1 because a facility contracted nurse told him Resident #1 probably did not need BP checks because the dosage of her blood pressure medication had been decreased. -He had not contacted Resident #1's PCP regarding Resident #1's BP checks. Interview with the Administrator on 08/12/22 at 9:05am revealed: -She was responsible for reviewing residents' FL2s. -She reviewed Resident #1's FL2, but she did not notice the order for BP checks 1 time a week. -Staff had not been checking Resident #1's BP weekly as ordered on the FL2.	C 249		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic menus for food service guidance for 1 of 3 sampled residents (#1) with physician's orders for a no concentrated sweets (NCS)/no	C 270	The current menu was updated by a reregistered dietitian reflecting therapeutic diets for NCS and NAS, as well as a few other diets. The updated/current menu has been posted and reviewed with staff to ensure each resident is being served from the correct diet at each meal and snack time. Staff has also been trained on checking fl2 to ensure each resident is receiving the correct per diet stated by physician.	09/30/22 09/26/22 <i>KB</i>

Division of Health Service Regulation

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C 270	Continued From page 6 added salt (NAS) diet. The findings are: Review of Resident #1's current FL2 revealed: -Diagnoses included type II diabetes mellitus, hypertension, and hyperlipidemia. -There was an order for a NCS/NAS diet. Observation of the kitchen on 08/11/22 at 10:05am revealed: -There was a regular diet menu on the refrigerator. -There were no therapeutic diet menus or a therapeutic diet list posted in the kitchen. Observation of the lunch meal on 08/11/22 at 1:05pm revealed: -Resident #1 was served a chicken patty sandwich with cheese on a hamburger bun, broccoli, canned peaches, water, and sugar free drink mix. -It could not be determined if Resident #1 was served the correct diet due to a NCS/NAS menu was not available. Telephone interview with a registered nurse from Resident #1's primary care physician's (PCP) office on 08/11/22 at 4:05pm revealed: -Resident #1 had diagnosis of diabetes with an A1C of 6.2 on 03/15/22 and a diagnosis of hypertension. -Resident #1 had an order for a NCS/NAS diet help manage her diabetes and hypertension and to decrease risks of an increase in her A1C, worsening diabetes, and heart attack. -The PCP expected the facility staff to serve Resident #1 a NCS/NAS diet according to a NCS/NAS menu.	C 270		

Division of Health Service Regulation

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C 270	Continued From page 7 Interview with the supervisor-in-charge (SIC) on 08/11/22 at 4:40pm revealed: -There was no NCS/NAS menu available in the facility. -He did not know Resident #1 should have been served meals following a NCS/NAS menu. -He knew Resident #1 was diabetic and served her gelatin and fresh fruit for desserts and snacks, and sugar free beverages and water. -He prepared food without adding any extra seasonings including salt. Interview with the Administrator on 08/12/22 at 9:05am revealed: -She did not know Resident #1 had an order for NCS/NAS diet. -She reviewed Resident #1's FL2, but she did not see the order for a NCS/NAS diet. -The facility did not have any therapeutic menus and all residents' meals were prepared using a regular diet menu. -She did not know the facility needed to have therapeutic diet menus for residents who had therapeutic diets. -The facility did not serve Resident #1 food items with high concentrated sugars. -Resident #1 was served meals from the regular diet menu, but staff served her sugar free pudding, gelatin, fresh fruit and sugar free beverages.	C 270		
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:	C 330		

Division of Health Service Regulation

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C 330	Continued From page 8 (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: Based on observations, record reviews, and interviews, the facility failed to administer medication as ordered by a prescribing practitioner to 1 of 3 sampled residents (#1) related to medications used to treat cholesterol. The findings are: a. Review of Resident #1's current FL2 dated 03/27/22 revealed: -Diagnoses included hyperlipidemia (high cholesterol). -There was an order for Lipitor (used to treat cholesterol) 20mg 1 tablet daily. Review of Resident #1's primary care physician's (PCP) after visit summary dated 03/17/22 revealed: -Resident #1 had a diagnosis of hyperlipidemia which was treated with medication. -There was an order to finish the current supply of simvastatin 10mg by increasing it to 20mg daily; start Lipitor 20mg once Resident #1 finished the current supply of simvastatin. Review of Resident #1's medication administration record (MAR) for June, July, and August 2022 revealed there was no entry for Lipitor 20mg 1 tablet daily. Observation of Resident #1's medications on hand revealed Lipitor 20mg 1 tablet daily was not available for administration.	C 330	On 8/11/22 the pharmacy was provided an updated copy of the residents FL2 form. The pharmacy came to pick up old medication pack and had the recorded updated the same day. The correct medication lipitor was provided the same day before the close of business for us to administer the next morning. As the administrator I will ensure that the pharmacy has an updated fl2 and medication orders at all times to ensure the resident is getting the correct medications and dosages. Staff was also informed and trained on changes. Staff was also trained on locating and verifying information on the residents fl2.	09/30/22 09/26/22 <i>KB</i>

Division of Health Service Regulation

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C 330	Continued From page 9 Telephone interview with the facility's contracted pharmacy on 08/11/22 at 2:17pm revealed: -The pharmacy had not dispensed Lipitor 20mg 1 tablet daily for Resident #1. -The pharmacy had not received Resident #1's FL2 dated 03/27/22 with the order for Lipitor 20mg or her physician's orders dated 03/17/22 to increase simvastatin to 20mg until the supply was finished and then start Lipitor 20mg. Interview with Resident #1 on 08/11/22 at 3:58am revealed she did not know if she had an order for Lipitor. Telephone interview with a registered nurse from Resident #1's primary care physician's (PCP) office on 08/11/22 at 4:05pm revealed: -She had a current order for Lipitor 20mg daily dated 03/17/22 which was used to treat high cholesterol. -Lipitor 20mg was prescribed for Resident #1 in place of simvastatin because simvastatin had been ineffective for Resident #1's cholesterol levels. -The PCP did not know Resident #1 was continuing to take simvastatin and had not started Lipitor 20mg once daily as ordered. -Resident #1's low density lipoprotein (LDL) cholesterol level was 78 on 03/17/22, and she had not been seen for another LDL cholesterol check since then. -The PCP expected Resident #1 to start Lipitor as ordered to decrease risks of clogged arteries and a heart attack. Interview with the supervisor-in-charge (SIC) on 08/11/22 at 4:40pm revealed: -He did not know Resident #1 had an order for Lipitor 20mg 1 tablet daily.	C 330		

Division of Health Service Regulation

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C 330	Continued From page 10 -He reviewed the residents' FL2s occasionally to see if the medication on the FL2 matched the medication available for the residents. -He had not noticed the order on Resident #1's FL2 for Lipitor. -The Administrator was responsible for sending the residents' FL2s to the pharmacy. Telephone interview with the Administrator on 08/12/22 at 9:05am revealed: -She was responsible for reviewing residents' PCP after visit summaries and physician's orders. -She reviewed Resident #1's PCP's after visit summary dated 03/17/22, but she did not see the order to increase simvastatin to 20mg, and start Lipitor 20mg daily once the simvastatin was finished. -She reviewed the medications on Resident #1's FL2, but she did not see the order for Lipitor 20mg daily and she did not see that there was no order for simvastatin. -She thought she had sent Resident #1's FL2 and physician's order to the pharmacy. b. Review of Resident #1's current FL2 dated 03/27/22 revealed: -Diagnoses included hyperlipidemia (high cholesterol). -There was not an order for simvastatin. Review of Resident #1's primary care physician's (PCP) after visit summary dated 03/17/22 revealed: -Resident #1 had a diagnosis of hyperlipidemia which was treated with medication. -There was an order to finish the current supply of simvastatin 10mg by increasing it to 20mg daily; start Lipitor 20mg once Resident #1 finished the current supply of simvastatin.	C 330		

Division of Health Service Regulation

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C 330	Continued From page 11 Review of resident #1's medication administration record (MAR) for June 2022 revealed: -There was an entry for simvastatin 10mg 1 tablet at bedtime scheduled for 8:00pm. -Simvastatin was documented as administered for 30 of 30 opportunities between 06/01/22 and 06/30/22. Review of resident #1's MAR for July 2022 revealed: -There was an entry for simvastatin 10mg 1 tablet at bedtime scheduled for 8:00pm. -Simvastatin was documented as administered for 31 of 31 opportunities from 07/01/22 through 07/31/22. Review of resident #1's MAR for August 2022 from 08/01/22 through 08/10/22 revealed: -There was an entry for simvastatin 10mg 1 tablet at bedtime scheduled for 8:00pm. -Simvastatin was documented as administered for 10 of 10 opportunities. Telephone interview with the facility's contracted pharmacy on 08/11/22 at 2:17pm revealed: -Resident #1 had a current order for simvastatin 10mg 1 tablet daily. -Simvastatin was dispensed to the facility on 06/01/22, 07/01/22, and 08/01/22 with a quantity of 30 tablets each time. -The pharmacy had not received an order to discontinue simvastatin. Interview with Resident #1 on 08/11/22 at 3:58am revealed she thought she had an order for simvastatin, but she did not know how much she was administered or how often, or why it was administered. Telephone interview with a registered nurse from	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/12/2022
NAME OF PROVIDER OR SUPPLIER SINCERE MANOR FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 334 ZEB ROAD GIBSONVILLE, NC 27249		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 12 Resident #1's primary care physician's (PCP) office on 08/11/22 at 4:05pm revealed: -The PCP changed Resident #1's cholesterol medication from simvastatin 10mg daily to Lipitor 20mg daily on 03/17/22 because simvastatin was not effective. -Resident #1's low density lipoprotein (LDL) cholesterol level was 03/17/22. -Resident #1's LDL cholesterol level had not been checked since 03/17/22, but she had an upcoming appointment in August 2022. Interview with the supervisor-in-charge (SIC) on 08/11/22 at 4:40pm revealed: -Simvastatin 10mg 1 tablet daily was on Resident #1's MAR and he administered simvastatin 10mg to Resident #1 during his shift. -He did not know about Resident #1's physician's order dated 03/17/22 to increase simvastatin to 20mg and once the simvastatin was finished, start Lipitor 20mg daily. -He did not know Resident #1 was no longer supposed to be administered simvastatin 10 daily. -The Administrator was responsible for reviewing FL2s and ensuring the FL2s were sent to the pharmacy. Interview with the Administrator on 08/12/22 at 9:05am revealed: -She was responsible for reviewing residents' PCP after visit summaries and physician's orders. -She reviewed Resident #1's PCP's after visit summary dated 03/17/22, but she did not see the order to increase simvastatin to 20mg and once the simvastatin was finished, start Lipitor 20mg daily. -She thought she had sent Resident #1's FL2 and physician's order to the pharmacy.	C 330		