

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/21/2022
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081		
NAME OF PROVIDER OR SUPPLIER THE ENCLAVE AT BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 13413 BUFFALO ROAD CLAYTON, NC 27527		
(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 initial survey on 12/20/22 - 12/21/22.	C 000	* See Attached POC. WW	
C 140	10A NCAC 13G .0405(e)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B, C) were tested for Tuberculosis (TB) disease upon hire according to control measures for the Commission for Public Health. The findings are: Review of the facility's license revealed an initial license was issued on 08/30/22 with an expiration date of 03/30/23. 1. Review of Staff B's personnel record revealed: -There was no hire date documented. -There were employee applications dated 05/17/22 and 08/28/22. -There was no position or job description	C 140		

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

TITLE

(X6) DATE

STATE FORM

6120

10H211

If continuation sheet 3 of 54

Reviewed and Acknowledged
03/13/23 WW

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C 140	Continued From page 1 documented. -Staff B had a tuberculosis (TB) skin test placed on 09/15/21 and read as negative on 09/17/21. -Staff B had a TB skin test placed on 10/03/22 and read as negative on 10/05/22. -There was no documentation of a second step TB skin test within 12 months of Staff B's TB skin tests completed on 09/17/21 or 10/05/22. Interview with Staff B on 12/21/22 at 5:12pm revealed: -She was the Facility Supervisor. -She or the Resident Coordinator (RC) were responsible for making sure staff TB tests were completed. -After her TB skin test was completed in September 2021, she did not realize a second step TB skin test had to be completed within 12 months. -She had another TB skin test completed on 10/05/22 after this facility opened. -She had not completed as second step TB skin test after 10/05/22. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. 2. Review of Staff C's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/22/21. -There was a job description dated 12/04/21 for Supervisor-in-Charge (SIC). -Staff C had a tuberculosis (TB) skin test placed on 10/03/22 and read as negative on 10/05/22. -There was no documentation of any other TB skin tests for Staff C. Interview with Staff C on 12/21/22 at 4:55pm revealed:	C 140			

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C 140	Continued From page 2 -She had worked here for "a year" (could not give exact date). -She was a medication aide (MA) and SIC. -She had not completed a second step TB skin test because she did not know she needed to have one done. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -The company had sister facilities, but this facility was licensed on 09/30/22. -All staff should have two-step TB skin tests completed upon hire. -He was supposed to have reviewed staff qualifications, including TB skin tests, when they started working at this facility. -He "slacked on" redoing some of the staff qualifications for staff working at this facility.	C 140			
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 staff (A, C) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry prior to hire at the facility.	C 145			

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C 145	Continued From page 3 The findings are: Review of the facility's license revealed an initial license was issued on 09/30/22 with an expiration date of 03/30/23. 1. Review of Staff A's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/11/22. -There was no position or job description documented. -There was a Health Care Personnel Registry (HCPR) check completed on 12/20/22 with no substantiated findings. Observation on 12/20/22 from 9:15am - 2:00pm revealed: -Staff A was working as the Supervisor-In-Charge (SIC) and medication aide (MA). -Staff A provided personal care, administered medications, and cooked and served meals to the residents. Interview with Staff A on 12/20/22 at 1:30pm revealed: -She had worked at this facility for "a few months" (could not give exact date). -She provided personal care to the residents and administered medications. -She also cooked meals, served the meals, and assisted residents with meals if needed. -She was not sure who was responsible for doing HCPR checks or if one had been completed. Interview with the Resident Coordinator (RC) on 12/21/22 at 4:33pm revealed a HCPR check was done yesterday, 12/20/22, for Staff A because she could not find a prior HCPR check for Staff A.	C 145		

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C 145	Continued From page 4 Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -Staff A started working with the company in 2021, left and came back in July 2021, and worked at a sister facility. -Staff A's personnel record needed to be updated "around September 2022" when she started working at this facility. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. 2. Review of Staff C's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/22/21. -There was a job description dated 12/04/21 for Supervisor-in-Charge (SIC). -There was a Health Care Personnel Registry (HCPR) check completed today, 12/21/22, with no substantiated findings. -There was no HCPR check prior to 12/21/22. Observation on 12/21/22 from 4:55pm to 5:45pm revealed Staff C provided personal care assistance, cooked, and served food to the residents. Interview with Staff C on 12/21/22 at 4:55pm revealed: -She had worked here for "a year" (could not give exact date). -She was a medication aide (MA) and SIC. -She was not sure who was responsible for doing HCPR checks or if one had been completed. Interview with the Resident Coordinator (RC) on 12/21/22 at 4:33pm revealed a HCPR check was done today, 12/21/22, for Staff C because she	C 145			

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C 145	Continued From page 5 could not find a prior HCPR check for Staff C. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -Staff C started working with the company in 2021 at a sister facility. -A HCPR check should have been completed when Staff C started working at this facility. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -This facility was licensed on 09/30/22. -He was supposed to have reviewed staff qualifications, including a HCPR checks, when staff started working at this facility. -He was responsible for completing HCPR checks for staff upon hire. -He "slacked" on doing the HCPR checks.	C 145			
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 staff (A, C) sampled had a criminal background check completed upon hire.	C 147			

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C 147	Continued From page 6 The findings are: Review of the facility's license revealed an initial license was issued on 09/30/22 with an expiration date of 03/30/23. 1. Review of Staff A's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/11/22. -There was no position or job description documented. -There was a statewide criminal background check completed on 05/12/21. -There was no criminal background check documented after 05/12/21. Observation on 12/20/22 from 9:15am - 2:00pm revealed: -Staff A was working as the Supervisor-in-Charge (SIC) and medication aide (MA). -Staff A provided personal care, administered medications, and cooked and served meals to the residents. Interview with Staff A on 12/20/22 at 1:30pm revealed: -She had worked at this facility for "a few months" (could not give exact date). -She provided personal care to the residents and administered medications. -She also cooked meals, served the meals, and assisted residents with meals if needed. -She thought a criminal background check had been completed but she was not sure when it was done. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -Staff A started working with the company in	C 147			

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C 147	Continued From page 7 2021, left and came back in July 2021, and worked at a sister facility. -Staff A's personnel record needed to be updated "around September 2022" when she started working at this facility. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. 2. Review of Staff C's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/22/21. -There was a job description dated 12/04/21 for Supervisor-in-Charge (SIC). -There was a statewide criminal background check completed on 12/07/21. -There was no criminal background check documented after 12/07/21. Observation on 12/21/22 from 4:55pm to 5:45pm revealed Staff C provided personal care assistance, cooked, and served food to the residents. Interview with Staff C on 12/21/22 at 4:55pm revealed: -She had worked here for "a year" (could not give exact date). -She was a medication aide (MA) and SIC. -She was not sure who was responsible for doing criminal background checks or if one had been completed. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -Staff C started working with the company in 2021 at a sister facility. -A criminal background check should have been completed when Staff C started working at this	C 147			

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C 147	Continued From page 8 facility. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -This facility was licensed on 09/30/22. -He was supposed to have reviewed staff qualifications, including criminal background checks, when staff started working at this facility. -He was responsible for completing the criminal background checks for staff upon hire. -He "slacked on" doing the criminal background checks.	C 147			
C 174	10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents 10A NCAC 13G .0505 Training On Care Of Diabetic Residents A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; appropriate administration times;	C 174			

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C 174	Continued From page 9 and (g) sliding scale insulin administration. This Rule Is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (A, B, C) had completed training on the care of diabetic residents prior to the administration of insulin. The findings are: 1. Review of Staff A's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/11/22. -There was no position or job description documented. -There was no documentation of completion of training on care of diabetic residents. Review of residents' December 2022 medication administration records (eMARs) revealed: -There was currently one resident residing in the facility with orders for insulin and the resident was admitted to the facility on 12/15/22. -Staff A documented administering insulin to the resident on 12/18/22, 12/19/22, and 12/20/22. Interview with Staff A on 12/20/22 at 1:30pm revealed: -She had worked at this facility for "a few months" (could not give exact date). -She was a medication aide (MA) and had been checked off by a registered nurse, completed the 5 and 10-hour MA training, and passed the MA written exam. -She had been a MA for 16 years at other facilities and had diabetes training but she could	C 174		

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C 174	Continued From page 10 not recall when. -She did not have any documentation of her diabetes training to her knowledge. -There was one resident at the facility who received Insulin and she had administered insulin to the resident since he was admitted about a week ago. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. 2. Review of Staff B's personnel record revealed: -There was no hire date documented. -There were employee applications dated 05/17/22 and 08/26/22. -There was no position or job description documented. -There was no documentation of completion of training on care of diabetic residents. Review of residents' December 2022 medication administration records (eMARs) revealed: -There was currently one resident residing in the facility with orders for insulin and the resident was admitted to the facility on 12/15/22. -Staff B documented administering insulin to the resident on 12/16/22 through 12/19/22. Interview with Staff B on 12/21/22 at 5:12pm revealed: -She was the Facility Supervisor. -There was currently one resident with orders to receive insulin. -She administered Insulin to the resident. -She had been checked off by a registered nurse to administer medications, including insulin. -She had not taken a class or had an In-service specific to training on the care of diabetic residents. -She was not aware training on the care of	C 174			

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C 174	Continued From page 11 diabetic residents was required prior to administering insulin. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. 3. Review of Staff C's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/22/21. -There was a job description dated 12/04/21 for Supervisor-In-Charge (SIC). -There was no documentation of completion of training on care of diabetic residents. Review of residents' December 2022 medication administration records (eMARs) revealed: -There was currently one resident residing in the facility with orders for two different insulins and the resident was admitted to the facility on 12/15/22. -Staff C documented administering insulin to the resident on 12/15/22, 12/16/22, and 12/19/22. Interview with Staff C on 12/21/22 at 4:55pm revealed: -She had worked here for "a year" (could not give exact date). -She was a medication aide (MA) and SIC. -She had been checked off by a registered nurse and completed the 15-hour MA training. -She was not sure if she had specific training on diabetes other than begin checked off. -She administered insulin to a new resident in the facility. Refer to telephone interview with the Administrator on 12/21/22 at 4:33pm. Telephone interview with the Administrator on	C 174			

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C 174	Continued From page 12 12/21/22 at 4:33pm revealed: -He thought the 5, 10, and 15-hour medication aide training included training on diabetes. -He was not aware of the rule requiring training on the care of diabetic residents prior to administering insulin.	C 174			
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule Is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 residents sampled (#1, #2) were tested for tuberculosis (TB) disease upon admission. The findings are: Review of the facility's license revealed an Initial license was issued on 09/30/22 with an expiration date of 03/30/23. 1. Review of Resident #1's current FL-2 dated 08/18/22 revealed no diagnoses were listed. Review of Resident #1's previous FL-2 dated	C 202			

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C 202	Continued From page 13 08/12/22 revealed diagnosis included dementia with behavioral disturbance. Review of Resident #1's Resident Register revealed a date of admission documented as 08/15/22. Review of Resident #1's tuberculosis (TB) skin tests revealed: -There was documentation of a TB skin test placed on 08/22/22 and read on 08/25/22 but the results were not documented. -There was no documentation of any other TB skin tests for Resident #1. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Telephone interview with Resident #1's power of attorney (POA) on 12/21/22 at 1:51pm revealed: -Resident #1 was admitted and moved into the facility on 08/14/22. -Resident #1 was never admitted to a sister facility for this company. -Resident #1 resided in another assisted living facility prior to going to the hospital and then to this facility on 08/14/22. Interviews with the Resident Coordinator (RC) on 12/20/22 at 11:35am and 12/21/22 at 4:33pm revealed: -Resident #1 was admitted to the facility on 08/14/22 from a local hospital. -She had not noticed the resident's TB skin test placed on 08/22/22 did not have the results documented when it was read on 08/25/22. -She was not sure if there were any other TB skin tests for Resident #1, but she could not locate any.	C 202			

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NAME OF PROVIDER OR SUPPLIER THE ENCLAVE AT BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 13413 BUFFALO ROAD CLAYTON, NC 27527			
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C 202	Continued From page 14 Telephone interview with Resident #1's primary care provider (PCP) on 12/21/22 at 3:54pm revealed: -She placed Resident #1's TB skin test on 08/22/22 and read it on 08/25/22. -Resident #1's TB skin test was negative on 08/25/22 and she must have forgotten to mark it on the form. -She thought Resident #1 also had a second TB skin test but she currently worked for a different company and no longer had access to the files of medical treatment she provided with the other company. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -All residents should have the required TB skin tests. -He was not aware Resident #1's TB skin test placed on 08/22/22 did not have the results of the reading documented. -Resident #1 was admitted to the facility in August 2022, prior to the facility being licensed. -Resident #1 was admitted prior to the facility's license effective date (09/30/22) because he was trying to keep things moving and he felt like the licensing process was taking too long. -Regardless of admission date, Resident #1 should have the required TB skin tests on file. 2. Review of Resident #2's current FL-2 dated 08/18/22 revealed diagnosis included dementia. Review of Resident #2's Resident Register revealed: -The name of the facility included the name for this facility and the name for a sister facility. -The date of admission was documented as September 2021.	C 202			

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C 202	Continued From page 15 Review of Resident #2's tuberculosis (TB) skin tests revealed there were no TB skin tests documented for Resident #2. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Interviews with the Resident Coordinator (RC) on 12/20/22 at 11:35am and 12/21/22 at 4:33pm revealed: -Resident #2 was admitted to this facility from a sister facility in August 2022. -She just transferred the paperwork from the sister facility for Resident #2. -Resident #2's TB skin tests should have been in her record. -She was unable to locate any TB skin tests for Resident #2. -She would check with the sister facility. Telephone interview with Resident #2's primary care provider (PCP) on 12/21/22 at 3:54pm revealed: -Resident #2 had two TB skin tests that were negative within the past year. -Documentation of the TB skin tests should have been on file at the facility. -She did not have access to documentation of the TB skin tests because she currently worked for a different company and no longer had access to the files of medical treatment she provided with the other company. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -All residents should have the required TB skin tests. -He was not aware Resident #2 did not have any	C 202			

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C 202	Continued From page 16 TB skin tests on file. -Resident #2 was admitted to the facility in August 2022 from a sister facility, prior to the facility being licensed. -Resident #2 was admitted prior to the facility's license effective date (09/30/22) because he was trying to keep things moving and he felt like the licensing process was taking too long. -Regardless of admission date, Resident #2 should have the required TB skin tests on file.	C 202			
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.	C 231			

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C 231	Continued From page 17 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure an annual assessment and care plan for 1 of 3 sampled residents (#1) was complete and included the resident's level of functioning who required extensive and/or total assistance with all activities of daily living. The findings are: Review of Resident #1's current FL-2 dated 08/18/22 revealed: -There were no diagnoses listed. -The information regarding orientation, ambulatory status, bowel and bladder, respirations, skin, behaviors, functional limitations, and personal care assistance was blank. Review of Resident #1's previous FL-2 dated 08/12/22 revealed: -Diagnosis included dementia with behavioral disturbance. -The resident was documented as constantly disoriented, semi-ambulatory, and incontinent of bladder and bowel. -The resident required personal care assistance for bathing and dressing. Review of Resident #1's Resident Register revealed: -The resident's date of admission was documented as 08/15/22. -The resident was documented as requiring assistance with dressing, bathing, nail care, shaving, getting in/out of bed, toileting, hair/grooming, mouth care and feeding. -The resident was documented as having significant memory loss and must be redirected.	C 231			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/21/2022
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C 231	Continued From page 18 Review of Resident #1's assessment and care plan revealed: -The assessment date was blank. -The resident was documented as non-ambulatory and used a wheelchair. -The resident was documented as having no problems with his upper extremities. -The resident's skin and respirations were documented as normal. -The resident was documented as having daily incontinence of the bladder. -The resident was documented as sometimes disoriented with significant memory loss - must be redirected. -The section of the care plan to assess the level of care assistance needed for eating, toileting, ambulation, bathing, dressing, grooming, and transferring was blank. -The section for the name and signature of the assessor and the date was blank. -The resident's primary care provider (PCP) signed and dated the assessment and care plan on 08/18/22. Observation of Resident #1 on 12/20/22 at 9:30am revealed: -The resident was sitting in a wheelchair in the living room. -The resident had an activity apron (an apron with bright colors and textures designed to help people with dementia to exercise fine motor skills and provide cognitive, tactile stimulation) on his lap. -The resident did not make eye contact when spoken to and he did not speak. Observation of Resident #1 on 12/20/22 at 9:50am revealed: -A staff person pushed the resident in his	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/21/2022
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C 231	Continued From page 19 wheelchair from the living room to the dining room. -Resident #1 initially required prompting for feeding but then required physical assistance by staff feeding him the meal and assisting the resident with holding his cups to his lips so he could drink his beverages. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Telephone interview with Resident #1's power of attorney (POA) on 12/21/22 at 1:51pm revealed: -Resident #1 was admitted and moved into the facility on 08/14/22. -Resident #1 needed assistance with all activities of daily living (ADLs) and she thought the resident needed two staff persons to assist the resident with showering. -The resident could stand with assistance, but he did not need to walk because he was at risk for falling. Interview with a medication aide/Supervisor-in-Charge (MA/SIC) on 12/20/22 at 1:30pm revealed: -Resident #1 usually required two-person assistance with getting in/out of bed, dressing, incontinence care, and showering. -Resident #1 required assistance with feeding if the food was something that he could not pick up by hand, like soup. -The resident required assistance with transferring and ambulation with the wheelchair. -The resident would stand up but he needed assistance because he was at risk for falls. -The resident fell about 3 months ago and hit his head, causing a bump on his head. -When the resident was first admitted, he was	C 231			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/21/2022
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C 231	Continued From page 20 agitated and would try to hit staff when staff was providing care to the resident but that had improved. Interview with a personal care aide (PCA) on 12/20/22 at 2:00pm revealed: -Resident #1 needed assistance with all ADLs. -The resident could stand up and bear weight but he was unsteady. -The resident had a fall about 3 months ago. -The resident was sometimes aggressive toward staff when staff was trying to provide incontinence care to the resident. -The resident had some redness on his buttocks at one time but they put ointment on it and it looked better. Telephone interview with Resident #1's PCP on 12/21/22 at 3:54pm revealed: -She did not recall the section for ADLs level of care being blank when she signed Resident #1's assessment and care plan on 08/18/22. -Resident #1 was total care with all ADLs and he required extensive assistance with feeding. Interview with the Resident Coordinator (RC) on 12/21/22 at 10:38am revealed: -She was responsible for completing the resident's assessment and care plans. -She had not noticed she left information blank on Resident #1's regarding the resident's level of care for ADLs. -The information on the assessment and care plan should be complete. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -He was not aware Resident #1's assessment and care plan were incomplete. -Resident #1's assessment and care plan should	C 231		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/21/2022
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C 231	Continued From page 21 be complete. -He relied on the RC or the Facility Supervisor to complete tasks at the facility such as assessments and care plans. -The RC and the facility's Supervisor should check behind each other to make sure tasks were completed.	C 231			
C 273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 8 ounces of milk was offered or served to the residents twice daily. The findings are: Review of the facility's Week 4 Menu revealed one 8 ounce cup of milk was to be served twice daily. Observation of the refrigerator on 12/20/22 at 10:46am revealed: -There was one plastic gallon jug of 2% milk.	C 273			

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C 273	Continued From page 22 -The gallon jug of milk was less than half full. Observation of the breakfast meal on 12/20/22 at 9:50am revealed: -All 5 residents were served apple juice and hot chocolate (made with water). -No milk was served or offered to the residents. Observation of the lunch meal on 12/20/22 at 12:25pm revealed: -All 5 residents were served sweet tea. -No milk was served or offered to the residents. Based on observations, interviews, and record reviews, it was determined that 5 of 5 residents residing in the facility were not interviewable. Interview with a medication aide/Supervisor-in-Charge (MA/SIC) on 12/20/22 at 1:30pm revealed: -She helped prepare and serve the residents' breakfast and lunch on 12/20/22. -She did not serve or offer milk to the residents at breakfast or lunch on 12/20/22. -She usually served milk if the resident had pancakes, waffles, or French toast for breakfast or if there was no juice to serve. -She sometimes served milk with snacks. -She had not served any milk to the residents today, 12/20/22. -She did not know milk was to be served twice a day according to the rules. Interview with a personal care aide (PCA) on 12/20/22 at 2:00pm revealed: -She helped prepare and serve the residents' breakfast and lunch on 12/20/22. -She did not offer or serve milk to the residents at breakfast or lunch today, 12/20/22. -The hot chocolate the resident's had for	C 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/21/2022
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C 273	Continued From page 23 breakfast was made with water, not milk. -Milk was mainly served at breakfast when it was served. -She was not aware milk should be served twice a day. Interviews with the Resident Coordinator (RC) on 12/20/22 at 10:55am and 5:00pm revealed: -She would be buying and bringing more milk to the facility today, 12/20/22. -She was not aware milk was not being served twice a day to the residents. -Milk should be served twice a day as indicated on the menu.	C 273			
C 280	10A NCAC 13G .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to serve water to residents during the breakfast and lunch meals on 12/20/22. The findings are: Review of the facility's Week 4 Menu revealed there was no documentation to indicate water was to be served at any meal or snack. Observation of the breakfast meal on 12/20/22 at	C 280			

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C 280	Continued From page 24 9:50am revealed: -All 5 residents were served apple juice and hot chocolate. -No water was served or offered to the residents. Observation of the lunch meal on 12/20/22 at 12:25pm revealed: -All 5 residents were served sweet tea. -No water was served or offered to the residents. Based on observations, interviews, and record reviews, it was determined that 5 of 5 residents residing in the facility were not interviewable. Interview with a medication aide/Supervisor-In-Charge (MA/SIC) on 12/20/22 at 1:30pm revealed: -She helped prepare and serve the residents' breakfast and lunch on 12/20/22. -She did not serve or offer water to the residents at breakfast or lunch on 12/20/22. -Water was available throughout the day for residents. -The residents usually drank water when it was offered. -She was not aware water was required to be served 3 times a day at each meal. Interview with a personal care aide (PCA) on 12/20/22 at 2:00pm revealed: -She helped prepare and serve the residents' breakfast and lunch on 12/20/22. -She did not offer or serve water to the residents at breakfast or lunch today, 12/20/22. -Water was served "as often as possible" but she could not specify a time frame. -Water was served at some meals but not every meal. -She was not aware water was required to be served 3 times a day at each meal.	C 280			

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C 280	Continued From page 25 Interviews with the Resident Coordinator (RC) on 12/20/22 at 10:55am and 5:00pm revealed: -She was not aware water was not being served at every meal. -Staff should serve water to the residents at every meal.	C 280		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 sampled residents (#1, #3) for rapid-acting Insulin and a medication for seizures (#3) and for a medication used as a sleep aid (#1). The findings are: 1. Review of Resident #3's current FL-2 dated	C 315		

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C 315	Continued From page 26 12/14/22 revealed diagnoses included dementia, diabetes mellitus type 2, essential hypertension, and aspiration pneumonitis. Review of Resident #3's facility contract revealed the resident was admitted to the facility on 12/15/22. a. Review of Resident #3's prescription order by the hospitalist dated 12/14/22 revealed: -There was an order for Novolog insulin with instructions to inject 4 units 3 times a day before meals. (Novolog is rapid-acting insulin used to lower blood sugar.) -The next line in the prescription read "take 10 units before breakfast, 12 units before lunch, 10 units before dinner". Review of Resident #3's hospital discharge summary dated 12/15/22 revealed: -There was an order for Novolog insulin inject 4 units 3 times a day before meals. -There was an order for Novolog Insulin inject 10 units before breakfast, 12 units before lunch, and 10 units before dinner. Review of Resident #3's physician's orders revealed no documentation the order for Novolog insulin was clarified. Review of Resident #3's December 2022 electronic medication administration record (eMAR) and paper MAR revealed: -There was an entry on the handwritten paper MAR for Novolog insulin inject 4 units 3 times daily before meals scheduled for 8:00am, 12:00pm, and 5:00pm. -Novolog 4 units was documented as administered from 12/16/22 - 12/19/22. -There was a handwritten entry on the paper	C 315			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/21/2022
NAME OF PROVIDER OR SUPPLIER THE ENCLAVE AT BUFFALO		STREET ADDRESS, CITY, STATE, ZIP CODE 13413 BUFFALO ROAD CLAYTON, NC 27527		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 315	Continued From page 27 MAR underneath the first Novolog entry to take 10 units before breakfast, 12 units before lunch, and 10 units before dinner with no scheduled administration times and none documented. -There was an entry on the eMAR for Novolog Insulin Inject 10 units 2 times a day before breakfast and dinner schedule for 7:00am and 4:00pm and documented as administered from 12/17/22 - 12/20/22. -There was a second entry on the eMAR for Novolog Insulin Inject 12 units at lunch scheduled at 12:00pm and documented as administered from 12/17/22 - 12/20/22. -The resident's blood sugar ranged from 118 - 272 from 12/15/22 - 12/21/22. Observation of Resident #3's medications on hand on 12/21/22 at 11:29am revealed: -There was a supply of Novolog insulin dispensed by a retail pharmacy on 11/23/22, prior to the resident's admission to the facility on 12/15/22. -The instructions on the label were to inject 10 units with breakfast and 12 units with lunch and dinner. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/21/22 at 3:12pm revealed: -The pharmacy entered medication orders into the eMAR system. -The facility staff had to review and approve the orders before they became active orders in the eMAR system. -They had a copy of Resident #3's hospital discharge summary dated 12/15/22 and he saw two different orders on the prescription for Novolog insulin. -The pharmacy staff entered the information under the instructions section of the prescription which was 10 units before breakfast and dinner	C 315		

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C 315	Continued From page 28 and 12 units before lunch. -The pharmacy had not dispensed any Novolog insulin yet because none had been requested by the facility. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Telephone interview with Resident #3's power of attorney (POA) on 12/21/22 at 2:11pm revealed: -Resident #3 was transported to the facility on 12/15/22 from a local hospital. -She took some medications to the facility from home when the resident was admitted on 12/15/22. -Prior to the hospitalization and admission to the facility, she thought the resident was receiving Novolog insulin 10 units before breakfast and dinner and 12 units before lunch. -She thought the hospitalist had discussed changing the dosage of Novolog insulin to 4 units 3 times a day while the resident was in the hospital but she was not sure if it was changed. Interview with the Facility Supervisor on 12/21/22 at 11:21am revealed: -She was a medication aide (MA) and administered medications to the residents, including Resident #3. -The resident was new and was just admitted to the facility about a week ago. -She administered Novolog insulin according to the instructions on the medication label. -She had not noticed the instructions on the medication label did not match the instructions on the MARs. -She had not noticed there were two different instructions for administering the Novolog Insulin on the orders and the MARs.	C 315			

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STATE FORM

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IQHZ11

If continuation sheet 29 of 54

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/21/2022
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C 315	Continued From page 29 Interview with the Resident Coordinator (RC) on 12/21/22 at 11:54am revealed: -The MAs were trained to make sure the medication labels and the eMARs matched. -If something did not match, the MAs were supposed to let her know so she could contact the provider and pharmacy for clarification. -She was responsible for clarification of medication orders and she had not noticed the discrepancy in the orders for Resident #3's Novolog Insulin. -She did not have a system to check orders and MARs because it had been difficult for her to keep up with things since the COVID-19 pandemic. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -He was not aware of the discrepancies with Resident #3's Novolog insulin order. -He relied on the RC or the Facility Supervisor to complete tasks at the facility including overseeing medication orders. -The RC and the Facility Supervisor should check behind each other to make sure tasks were completed. Telephone interview with Resident #3's primary care provider (PCP) on 12/21/22 at 3:54pm revealed: -Resident #3 was a new resident at the facility and she had not had a visit to the facility since the resident was admitted. -She was not aware of any clarification issues with Resident #3's Novolog insulin. -No one from the facility had contacted her to clarify any orders for Resident #3. b. Review of Resident #3's hospital discharge	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/21/2022
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C 315	Continued From page 30 summary dated 12/15/22 revealed an order for Tegretol XR 400mg take 1 tablet 2 times a day. (Tegretol XR is an extended-released medication used to treat seizure disorders.) Review of Resident #3's December 2022 electronic medication administration record (eMAR) and paper MAR revealed: -There were entries for Tegretol XR 400mg take 1 tablet two times a day for seizures scheduled for 8:00am and 8:00pm. -Tegretol XR 400mg was documented as administered from 12/16/22 - 12/20/22. Observation of Resident #3's medications on hand on 12/20/22 at 5:08pm revealed: -There was a supply of Tegretol dispensed by a retail pharmacy on 09/19/22, prior to the resident's admission to the facility on 12/15/22. -The supply of Tegretol was 200mg tablets and the tablets were not extended-released (XR). -The instructions on the label were to take 1 tablet by mouth twice a day for 30 days. -There was no Tegretol XR 400mg tablets on hand for Resident #3. Review of Resident #3's physician's orders revealed no documentation the order for Tegretol XR was clarified. Telephone interview with a pharmacist from the facility's contracted pharmacy on 12/21/22 at 3:12pm revealed: -The pharmacy entered medication orders into the eMAR system. -The facility staff had to review and approve the orders before they became active orders in the eMAR system. -The pharmacy had copy of Resident #3's hospital discharge summary dated 12/15/22 with	C 315		

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C 315	Continued From page 31 an order for Tegretol XR 400mg twice a day and that was what they entered into the eMAR system. -The pharmacy had not dispensed any Tegretol XR 400mg tablets yet because none had been requested by the facility. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable. Telephone interview with Resident #3's power of attorney (POA) on 12/21/22 at 2:11pm revealed: -Resident #3 was transported to the facility on 12/15/22 from a local hospital. -She took some medications to the facility from home when the resident was admitted on 12/15/22. -Tegretol 200mg twice a day was the current dose the resident was supposed to take prior to going to the hospital. -The resident had taken Tegretol XR 400mg twice a day in the past but it was decreased in the past because the resident was having side effects on that dosage. -The resident had a history of localized seizures in his left hand that caused a tremor but he had not had any seizures "in a while". Interview with the Facility Supervisor on 12/21/22 at 11:21am revealed: -She was a medication aide (MA) and administered medications to the residents, including Resident #3. -She had been administering one Tegretol 200mg tablet to Resident #3 twice a day according to the medication label. -She had not noticed the instructions on the eMAR were for Tegretol XR 400mg twice a day. -The resident was new and was just admitted to	C 315		

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C 315	Continued From page 32 the facility about a week ago. -The resident had no seizures to her knowledge while at the facility. Interview with the Resident Coordinator (RC) on 12/21/22 at 11:54am revealed: -The MAs were trained to make sure the medication labels and the eMARs matched. -If something did not match, the MAs were supposed to let her know so she could contact the provider and pharmacy for clarification. -She was responsible for clarification of medication orders and she had not noticed the discrepancy with Resident #3's Tegretol. -She did not have a system to check orders and eMARs because it had been difficult for her to keep up with things since the COVID-19 pandemic. Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -He was not aware of the discrepancies with Resident #3's Tegretol. -He relied on the RC or the Facility Supervisor to complete tasks at the facility including overseeing medication orders. -The RC and the facility's Supervisor should check behind each other to make sure tasks were completed. Telephone interview with Resident #3's primary care provider (PCP) on 12/21/22 at 3:54pm revealed: -Resident #3 was a new resident at the facility and she had not had a visit to the facility since the resident was admitted. -She was not aware of any clarification issues with Resident #3's Tegretol. -No one from the facility had contacted her to clarify any orders for Resident #3.	C 315			

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C 315	Continued From page 33 2. Review of Resident #1's current FL-2 dated 08/18/22 revealed: -There were no diagnoses listed. -There was an order for Melatonin 3mg 1 tablet at bedtime. (Melatonin is a supplement used as a sleep aid.) Review of Resident #1's previous FL-2 dated 08/12/22 revealed diagnosis included dementia with behavioral disturbance. Review of Resident #1's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Melatonin 3mg take 2 tablets (6mg) at bedtime for sleep scheduled at 8:00pm. -Melatonin 3mg 2 tablets (6mg) was documented as administered at 8:00pm from 10/01/22 - 10/31/22. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for Melatonin 3mg take 2 tablets (6mg) at bedtime for sleep scheduled at 8:00pm. -Melatonin 3mg 2 tablets (6mg) was documented as administered at 8:00pm from 11/01/22 - 11/30/22. Review of Resident #1's December 2022 eMAR revealed: -There was an entry for Melatonin 3mg take 2 tablets (6mg) at bedtime for sleep scheduled at 8:00pm. -Melatonin 3mg 2 tablets (6mg) was documented as administered at 8:00pm from 12/01/22 - 12/19/22.	C 315			

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C 315	Continued From page 34 Review of Resident #1's primary care provider (PCP) visit note dated 09/22/22 revealed: -The PCP noted the resident was confused, non-verbal, and did not follow commands. -Staff reported no concerns with sleep. -The resident's list of current medications included Melatonin 3mg 1 tablet at bedtime. -The resident was noted to be stable on the current dose of Melatonin. -The PCP noted there were no plans to change the resident's current medication management. Observations of Resident #1's medications on hand on 12/20/22 at 5:06pm and 12/21/22 at 9:53am revealed: -There was a supply of Melatonin 3mg tablets dispensed on 11/18/22. -The instructions on the Melatonin label were to take 2 tablets (6mg) at bedtime for sleep. Telephone interview with a pharmacist at the facility's contracted pharmacy on 12/21/22 at 3:12pm revealed: -The pharmacy had an order from Resident #1's hospital discharge summary dated 08/15/22 for Melatonin 6mg at bedtime. -The pharmacy did not receive Resident #1's FL-2 dated 08/18/22 with an order for Melatonin 3mg at bedtime. Interview with the Facility Supervisor on 12/21/22 at 9:48am revealed: -She was a medication aide (MA) and administered medications to the residents, including Resident #1. -She had administered two Melatonin 3mg tablets to Resident #1 as indicated on the eMARs and the medication label. -She had not noticed the most current order on the FL-2 dated 08/18/22 was for one tablet of	C 315			

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C 315	Continued From page 35 Melatonin 3mg tablets. -The order needed to be clarified. Interview with the Resident Coordinator (RC) on 12/21/22 at 10:38am revealed: -She was responsible for clarifying medication orders. -She had not noticed the discrepancy with Resident #1's Melatonin. Telephone interview with Resident #1's PCP on 12/21/22 at 3:54pm revealed: -She could not recall if Resident #1's current dose of Melatonin 3mg was 1 or 2 tablets as she did not currently have access to her records. -If the facility had a discrepancy or was unsure of the correct dosage, the facility staff should have contacted her for clarification. -She was not aware of any current problems with Resident #1's sleep.	C 315			
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	C 342			

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C 342	Continued From page 36 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 (#1, #3) including inaccurate documentation of a medication for a rapid-acting insulin and a medication for seizures (#3) and a medication for mood disorders (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 12/14/22 revealed diagnoses included dementia, diabetes mellitus type 2, essential hypertension, and aspiration pneumonitis. Review of Resident #3's facility contract revealed the resident was admitted to the facility on 12/15/22. a. Review of Resident #3's hospital discharge summary dated 12/15/22 revealed: -There was an order for Novolog Insulin inject 4 units 3 times a day before meals. -There was an order for Novolog insulin inject 10 units before breakfast, 12 units before lunch, and 10 units before dinner. (Novolog is rapid-acting insulin used to lower blood sugar.) Review of Resident #3's December 2022 electronic medication administration record (eMAR) and paper MAR revealed:	C 342		

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C 342	Continued From page 37 -There was an entry on the handwritten paper MAR for Novolog insulin inject 4 units 3 times daily before meals scheduled for 8:00am, 12:00pm, and 5:00pm. -Novolog 4 units was documented as administered from 12/16/22 - 12/19/22. -There was a handwritten entry on the paper MAR underneath the first Novolog entry to take 10 units before breakfast, 12 units before lunch, and 10 units before dinner with no scheduled administration times and none documented. -There was an entry on the eMAR for Novolog Insulin inject 10 units 2 times a day before breakfast and dinner schedule for 7:00am and 4:00pm and documented as administered from 12/17/22 - 12/20/22. -There was a second entry on the eMAR for Novolog insulin inject 12 units at lunch scheduled at 12:00pm and documented as administered from 12/17/22 - 12/20/22. -The resident's blood sugar ranged from 118 - 272 from 12/15/22 - 12/21/22. Observation of Resident #3's medications on hand on 12/21/22 at 11:29am revealed: -There was a supply of Novolog insulin dispensed by a retail pharmacy on 11/23/22, prior to the resident's admission to the facility on 12/15/22. -The instructions on the label were to inject 10 units with breakfast and 12 units with lunch and dinner. Interview with the Facility Supervisor on 12/21/22 at 11:21am revealed: -She was a medication aide (MA) and administered medications to the residents, including Resident #3. -She administered Novolog Insulin according to the instructions on the medication label. -She had not noticed the instructions on the	C 342			

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C 342	Continued From page 38 medication label did not match the instructions on the eMAR. -She had not noticed there were two different instructions for administering the Novolog insulin on the orders and the eMAR. -She could not explain why documentation on the MARs did not match how the insulin was actually being administered. Interview with the Resident Coordinator (RC) on 12/21/22 at 11:54am revealed: -The MAs were supposed to make sure documentation on the eMAR matched how they were actually administering the medications. -She did not have a system to check orders and eMARs because it had been difficult for her to keep up with things since the COVID-19 pandemic. Telephone Interview with the Administrator on 12/21/22 at 4:33pm revealed: -He was not aware Resident #3's eMARs were not accurate. -He relied on the RC or the Facility Supervisor to complete tasks at the facility including overseeing eMAR documentation. -The RC and the Facility Supervisor should check behind each other to make sure tasks were completed. b. Review of Resident #3's hospital discharge summary dated 12/15/22 revealed an order for Tegretol XR 400mg take 1 tablet 2 times a day. (Tegretol XR is an extended-released medication used to treat seizure disorders.) Review of Resident #3's December 2022 electronic medication administration record (eMAR) and paper MAR revealed: -There were entries for Tegretol XR 400mg take 1	C 342		

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C 342	Continued From page 39 tablet two times a day for seizures scheduled for 8:00am and 8:00pm. -Tegretol XR 400mg was documented as administered from 12/16/22 - 12/20/22. Observation of Resident #3's medications on hand on 12/20/22 at 5:08pm revealed: -There was a supply of Tegretol dispensed by a retail pharmacy on 09/19/22, prior to the resident's admission to the facility on 12/15/22. -The supply of Tegretol was 200mg tablets and the tablets were not extended-released (XR). -The instructions on the label were to take 1 tablet by mouth twice a day for 30 days. -There was no Tegretol XR 400mg tablets on hand for Resident #3. Interview with the Facility Supervisor on 12/21/22 at 11:21am revealed: -She was a medication aide (MA) and administered medications to the residents, including Resident #3. -She had been administering one Tegretol 200mg tablet to Resident #3 twice a day according to the medication label. -She had not noticed the instructions on the eMAR were for Tegretol XR 400mg twice a day and that did not match the medication being administered. Interview with the Resident Coordinator (RC) on 12/21/22 at 11:54am revealed: -The MAs were supposed to make sure documentation on the eMAR matched how they were actually administering the medications. -She did not have a system to check orders and eMARs because it had been difficult for her to keep up with things since the COVID-19 pandemic.	C 342		

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C 342	Continued From page 40 Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -He was not aware Resident #3's eMARs were not accurate. -He relied on the RC or the Facility Supervisor to complete tasks at the facility including overseeing eMAR documentation. -The RC and the Facility Supervisor should check behind each other to make sure tasks were completed. 2. Review of Resident #1's current FL-2 dated 08/18/22 revealed: -There were no diagnoses listed. -There was an order for Depakote 125mg 1 capsule 3 times a day. (Depakote may be used to treat mood disorders and behaviors.) Review of Resident #1's previous FL-2 dated 08/12/22 revealed diagnosis included dementia with behavioral disturbance. Review of Resident #1's October 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote 125mg take 1 capsule 3 times daily for mood scheduled at 8:00am, 2:00pm, and 8:00pm. -Documentation for Depakote was blank on 8 occasions at 2:00pm on 10/03/22, 10/05/22, 10/06/22, 10/11/22, 10/12/22, 10/17/22, 10/18/22, and 10/24/22. -There were no reasons for the omissions documented. Review of Resident #1's November 2022 eMAR revealed: -There was an entry for Depakote 125mg take 1 capsule 3 times daily for mood scheduled at 8:00am, 2:00pm, and 8:00pm.	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/21/2022
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C 342	Continued From page 41 -Documentation for Depakote was blank on 15 occasions at 2:00pm on 11/03/22 - 11/05/22, 11/07/22, 11/09/22, 11/10/22, 11/14/22 - 11/17/22, 11/22/22, 11/23/22, and 11/27/22 - 11/29/22. -There were no reasons for the omissions documented. Review of Resident #1's December 2022 eMAR revealed: -There was an entry for Depakote 125mg take 1 capsule 3 times daily for mood scheduled at 8:00am, 2:00pm, and 8:00pm. -Documentation for Depakote was blank on 6 occasions at 2:00pm on 12/07/22, 12/08/22, 12/11/22 - 12/13/22, and 12/19/22. -There were no reasons for the omissions documented. Review of Resident #1's primary care provider (PCP) visit note dated 09/22/22 revealed: -The PCP noted the resident was confused, non-verbal, and did not follow commands. -Staff reported no concerns with behaviors. -The resident's list of current medications included Depakote 125mg 1 capsule 3 times a day. -The resident was noted to be stable on the current dose of Depakote. -The PCP noted to no plans to change the resident's current medication management. Observations of Resident #1's medications on hand on 12/20/22 at 5:06pm and 12/21/22 at 9:53am revealed: -There was a supply of Depakote 125mg capsules dispensed on 09/19/22 with 4 of 90 capsules remaining. -There was a supply of Depakote 125mg capsules dispensed on 10/19/22 with 30 of 90 capsules remaining.	C 342			

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C 342	Continued From page 42 -There was a supply of Depakote 125mg capsules dispensed on 11/18/22 with 12 of 90 capsules remaining. Interview with the Facility Supervisor on 12/21/22 at 9:48am revealed: -She was a medication aide (MA) and administered medications to the residents, including Resident #1. -She was unsure why there were omissions for Resident #1's Depakote. -The resident usually took his medication without refusing and there was Depakote on hand. -The MAs should document on the eMAR when medications were administered, or they should document a reason if a medication was not administered. Interview with the Resident Coordinator (RC) on 12/21/22 at 10:38am revealed: -The MAs were supposed to document on the eMAR when a medication was administered. -There should not be any blanks on the eMARs and she was not aware of the omissions for Resident #1's Depakote. -She did not have a system to check the eMARs for accuracy. -It had been difficult for her to complete her tasks since the COVID-19 pandemic. Telephone interview with Resident #1's PCP on 12/21/22 at 3:54pm revealed: -Resident #1 was taking Depakote for mood due to dementia with behaviors, including a history of combative behavior. -She was not aware of any missed doses of Depakote and no current behavioral issues with the resident.	C 342			

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C 453	Continued From page 43	C 453		
C 453	10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives 10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES (a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that	C 453		

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C 453	Continued From page 44 monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a physical restraint was used with a written order after an assessment and care planning process had been completed for 1 of 1 sampled resident (#1) with an activity apron tied around the back of the resident's wheelchair preventing the resident from leaning forward and standing up from his wheelchair due to the resident being at risk for falls. The findings are: Review of Resident #1's current FL-2 dated 08/18/22 revealed: -There were no diagnoses listed. -The information regarding orientation, ambulatory status, bowel and bladder, respirations, skin, behaviors, functional limitations, and personal care assistance was blank. Review of Resident #1's previous FL-2 dated 08/12/22 revealed: -Diagnosis included dementia with behavioral disturbance. -The resident was documented as constantly disoriented, semi-ambulatory, and incontinent of bladder and bowel. -The resident required personal care assistance	C 453			

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C 453	Continued From page 45 for bathing and dressing. Review of Resident #1's Resident Register revealed: -The resident's date of admission was documented as 08/15/22. -The resident was documented as requiring assistance with dressing, bathing, nail care, shaving, getting in/out of bed, toileting, hair/grooming, mouth care and feeding. -The resident was documented as having significant memory loss and must be redirected. Review of Resident #1's assessment and care plan revealed: -The assessment date was blank. -The resident was documented as non-ambulatory and used a wheelchair. -The resident was documented as having no problems with his upper extremities. -The resident's skin and respirations were documented as normal. -The resident was documented as having daily incontinence of the bladder. -The resident was documented as sometimes disoriented with significant memory loss - must be redirected. -The section of the care plan to assess the level of care assistance needed for eating, toileting, ambulation, bathing, dressing, grooming, and transferring was blank. -The section for the name and signature of the assessor and the date was blank. -The resident's primary care provider (PCP) signed and dated the assessment and care plan on 08/18/22. -There was no documentation regarding the use of any physical restraints for the resident. Observation of Resident #1 on 12/20/22 at	C 453		

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C 453	Continued From page 46 9:30am revealed: -The resident was sitting in a wheelchair in the living room. -The resident had an activity apron (an apron with bright colors and textures designed to help people with dementia to exercise fine motor skills and provide cognitive, tactile stimulation) on his body from the chest area down to his lap. -The activity apron had two white straps on each side of the apron. -Both straps of the activity apron were pulled around the resident to the back of the wheelchair. -Both straps were wrapped around the vertical metal bars that connected the arms of the wheelchair to the bottom horizontal bar near the wheels of the wheelchair. -The straps were then pulled together and tied in a bow in the center of the back of the wheelchair. -The resident could not reach the tied straps behind the wheelchair to release the straps of the activity apron. -The resident was rocking and leaning forward at times, but the tied activity apron prevented the resident from reaching down and from getting up. -The resident did not make eye contact when spoken to and he did not speak. Observation of Resident #1 on 12/20/22 at 10:58am revealed: -Resident #1 was still sitting in his wheelchair with the activity apron tied around the back of the wheelchair. -The resident was leaning forward in the wheelchair, which was near the kitchen island. Review of Resident #1's physician's orders revealed no orders for the use of any physical restraint. Based on observations, interviews, and record	C 453			

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C 453	Continued From page 47 reviews, it was determined Resident #1 was not interviewable. Interviews with a medication aide/Supervisor-in-Charge (MA/SIC) on 12/20/22 at 10:58am and 1:30pm revealed: -Resident #1 usually required two-person assistance with getting in/out of bed, dressing, incontinence care, and showering. -The resident required assistance with transferring and ambulation with the wheelchair. -The resident would stand up but he needed assistance because he was at risk for falls. -The resident fell about 3 months ago and hit his head, causing a bump on his head. -Resident #1 had the activity apron since he was admitted to the facility. -Another staff showed her how to tie the activity apron around the resident and behind the wheelchair but she did not recall which staff. -She tied the apron around the wheelchair because Resident #1 would lean forward or try to stand up and could fall. -Tying the apron around the wheelchair prevented the resident from getting up and falling out of the chair. -She did not know the apron tied around the wheelchair was considered a physical restraint. Interview with a personal care aide (PCA) on 12/20/22 at 2:00pm revealed: -Resident #1 needed assistance with all activities of daily living. -The resident could stand up and bear weight but he was unsteady. -The resident had a fall a few months ago. -The resident would lean forward and reach for things on the floor while in his wheelchair. -The resident had the activity apron for "a while" but she could not recall the exact date.	C 453			

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C 453	Continued From page 48 -She tied the activity apron around the resident and behind the wheelchair because that was the way other staff did it and it had always been done that way. Telephone interview with Resident #1's power of attorney (POA) on 12/21/22 at 1:51pm revealed: -Resident #1 was admitted and moved into the facility on 08/14/22. -The resident could stand with assistance, but he did not need to walk because he was at risk for falling. -The resident had one fall out of bed since being admitted to the facility; he hit his head but did not need to go to the hospital. -She took the activity apron to the facility on the same day the resident was admitted and asked the staff to keep the apron on the resident when he was in the wheelchair. -She put the activity apron on the resident in his wheelchair on the day he was admitted and she tied the apron to the back of the wheelchair because the resident would try to get up. -The resident was at risk for falling because he would lean forward and try to get up or reach for something on the floor. -She was not aware the activity apron tied behind the resident's wheelchair was a restraint. Telephone interview with Resident #1's PCP on 12/21/22 at 3:54pm revealed: -She thought Resident #1 had one fall since being admitted to the facility but she could not recall the date. -The resident's activity apron should be tied around his waist. -The activity apron was not intended to be tied around the wheelchair. -She did not recall seeing the activity apron tied around the resident's wheelchair.	C 453			

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C 453	Continued From page 49 -The facility had not requested an order for a physical restraint for Resident #1. -She would expect the facility to use a proper physical restraint that could be easily removed. Interview with the Resident Coordinator (RC) on 12/20/22 at 11:04am revealed: -She could not recall if Resident #1 had fallen but she had no accident/incident reports for the resident. -The resident's family member wanted the facility staff to use the activity apron to keep the resident busy. -The facility staff had tied the activity apron around the resident's wheelchair since the resident's family brought the apron to the facility (could not recall date). -She was not aware tying the resident's apron around the wheelchair to prevent the resident from getting up and falling was considered a physical restraint. -She thought the use of the apron had "transgressed" into something that it was not supposed to be. -There was no order for the resident to have a physical restraint and there had been no assessment or care planning process or alternatives for a physical restraint.	C 453			
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is	C992			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL051081	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/21/2022
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C992	Continued From page 50 conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 2 of 3 staff (A, C) sampled who were hired after 10/01/13. The findings are: Review of the facility's license revealed an initial license was issued on 09/30/22 with an expiration	C992			

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C992	Continued From page 51 date of 03/31/23. 1. Review of Staff A's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/11/22. -There was no position or job description documented. -There was no documentation of a controlled substance screening for Staff A dated 10/03/22. -The test result section to mark negative or positive was left blank. -The controlled substance screening result form was signed by Staff A and the facility's Supervisor. Observation on 12/20/22 from 9:15am - 2:00pm revealed: -Staff A was working as the Supervisor-in-Charge (SIC) and medication aide (MA). -Staff A provided personal care, administered medications, and cooked and served meals to the residents. Interview with Staff A on 12/20/22 at 1:30pm revealed: -She had worked at this facility for "a few months" (could not give exact date). -She provided personal care, administered medications, and cooked meals for the residents. -She had a drug screening around the time she was hired but she could not recall the date. Interview with the Facility Supervisor on 12/21/22 at 5:12pm revealed: -She completed the controlled substance screening for Staff A. -She forgot to mark Staff A's controlled substance screening as negative on the form dated 10/03/22.	C992			

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C992	Continued From page 52 Telephone interview with the Administrator on 12/21/22 at 4:33pm revealed: -This facility was licensed on 09/30/22. -Staff A started working with the company in 2021, left and came back in July 2021, and worked at a sister facility. -He was not aware Staff A's controlled substance screening form did not have the results documented. -He usually took pictures of the controlled substance screening test kit results to keep on file with the form but he forgot to do that for Staff A. 2. Review of Staff C's personnel record revealed: -There was no hire date documented. -There was an employee application dated 11/22/21. -There was a job description dated 12/04/21 for Supervisor-in-Charge (SIC). -There was documentation of a controlled substance screening for Staff C dated 11/22/21 that was negative. -There was no documentation of a controlled substance screening for Staff C when the facility was first licensed on 09/30/22. Observation on 12/21/22 from 4:55pm to 5:45pm revealed Staff C provided personal care assistance, took, and served food to the residents. Interview with Staff C on 12/21/22 at 4:55pm revealed: -She had worked here for "a year" (could not give exact date). -She was a medication aide (MA) and SIC. -She had one controlled substance screening about a year ago.	C992			

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C992	Continued From page 53 Telephone interview with the Administrator on 12/21/22 at 1:33pm revealed: -This facility was licensed on 09/30/22. -Staff C started working with the company in 2021 at a sister facility. -There should have been a controlled substance screening completed when Staff C started working at this facility. -He "slacked on" re-doing some of the qualification of staff when this facility was licensed.	C992			



The Enclave

Initial Survey completed 12/21/2022
Community: The Enclave at Buffalo
License – FCL051081
County- Johnston County

10A NCAC 13G .0405 TEST FOR TUBERCULOSIS

- (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments.
- (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease.

This Rule is not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B, C) were tested for Tuberculosis (TB) disease upon hire according to control measures for the Commission for Public Health.

Plan of Correction

To ensure the proper Tuberculosis requirement is satisfied. The Enclave will develop a new monitoring protocol to ensure that all staff members have met the 2 - step TB skin test requirement. The Enclave monitoring protocol will ensure that all staff members will have satisfied the requirement within 30 days of hire. The Enclave will only hire staff members that present the proper Tuberculosis testing paperwork. The House Supervisor will request a 2 -step TB skin test from the potential employee on the date of the interview of the potential staff member. If the staff member has not met the second test requirement, the potential staff member will have ten days after the date of hire. The House Supervisor will request the second Tuberculosis test, in accordance with the rule. If the test is not completed within 30 days of hire, the staff member will be taken off the work schedule. Once all requirements are fulfilled, and confirmed by the House Supervisor, the staff member will be put back on the work schedule. All employee documents including all tuberculosis test will be scanned and uploaded onto The Enclave's online folder. This will aid the Administrator with the monthly staff audits and act as an added safeguard against lost physical paper documents. The House Supervisor will be trained on the proper procedure.



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Notes:

If there is not a House Supervisor, the Administrator will assume this duty until a suitable candidate is available. An audit of employee files will be completed by the Administrator every 90 days to ensure all staff requirements are met.

Timeline to Complete:

Procedure to be completed 1/13/23
The House Supervisor will be reporting staff requirements at our weekly meetings addressed



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10A NCAC 13G .0406(a)(5) OTHER STAFF QUALIFICATIONS

Each staff person of a family care home shall:

- (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 staff (A, C) sampled had no substantiated findings on the North Carolina Health Care Personnel Registry prior to hire at the facility

Plan of Correction

To ensure the North Carolina Health Care Personnel Registry requirement is met, The Enclave House Supervisor will complete the Health Care Personnel Registry after each interview of a potential staff member. All employee documents including the Health Personnel Registry will be scanned and uploaded onto The Enclave's online folder. This will aid the Administrator with the monthly staff audits and act as an added safeguard against lost physical paper documents. The House Supervisor will be trained on the proper procedure.

Notes - If there is not a House Supervisor to perform an interview and complete the onboarding process, the Administrator will assume this duty until a suitable candidate is available.

There was an audit done on all staffing files 1/13/23 to ensure that all correct qualifications were up to date. An audit will be performed every 90 days. The Administrator will oversee each audit every 90 days.

Timeline to Complete:

This protocol was addressed 1/13/23 and will be addressed monthly on an ongoing basis.



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10A NCAC 13G .0406(a)(⁷§) OTHER STAFF QUALIFICATIONS

Each staff person of a family care home shall:

(7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file;

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 staff (A, C) sampled had a criminal background check completed upon hire.

Plan of Correction

To ensure each staff person of a family care home shall have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; will develop an on-boarding protocol to ensure each staff member has a completed.

Notes –

The House Supervisor will complete this task of on-boarding employees. If there isn't a House Supervisor, the Administrator will assume this duty until a suitable candidate is available.

There was an audit done on all staffing files 1/13/23 to ensure that all correct qualifications were up to date. An audit will be performed every 90 days. The Administrator will oversee each audit every 90 days.

Timeline to complete –

Policy completed 1/28/23

Protocol implemented- 1/28/23



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10A NCAC 13G .0505 (1)(2) TRAINING ON CARE OF DIABETIC RESIDENTS

A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows:

- (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.
- (2) Training shall include at least the following:
 - (a) basic facts about diabetes and care involved in the management of diabetes;
 - (b) insulin action;
 - (c) insulin storage;
 - (d) mixing, measuring and injection techniques for insulin administration;
 - (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;
 - (f) blood glucose monitoring; universal precautions; appropriate administration times; and
 - (g) sliding scale insulin administration.

This Rule is not met as evidenced by:

Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (A, B, C) had completed training on the care of diabetic residents prior to the administration of insulin.

Plan of Correction:

To ensure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration. Staff members will need to complete and pass an Inservice training course, Diabetes Care and Insulin Administration provided by Contracted Pharmacy, during their orientation day prior to working within the home as a staff member.

Notes –

The training will be monitored by The House Supervisor If there isn't a House Supervisor to complete the on-boarding process, the Administrator will assume this duty until a suitable candidate is available

There was an audit done on all staffing files 1/13/23 to ensure that all correct qualifications were up to date. An audit will be performed every 90 days. The Administrator will oversee each audit every 90 days.

Timeline to complete –

All existing staff will complete the state approved training -2/1/23



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10A NCAC 13G .0702 TUBERCULOSIS TEST AND MEDICAL EXAMINATION

(a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:

Based on record reviews and interviews, the facility failed to ensure 2 of 3 residents sampled (#1, #2) were tested for tuberculosis (TB) disease upon admission.

Plan of Correction-

To ensure, upon admission into The Enclave each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC41A.205, The resident coordinator will develop a check list that ensures all new admissions have completed both or 1 of the Tuberculosis tests needed for admission.

Notes-

There was an audit done on all Resident files 1/13/23 to ensure that all correct qualifications were up to date. An audit will be performed every 90 days. Resident Coordinator will oversee each audit every 90 days.

Timeline to complete-

Checklist completed- 2/01/23

Existing residents TB skin test completed -1/26/23



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10A NCAC 13G .0801(b)RESIDENT 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 observations, interviews, and record reviews, the facility failed to ensure an annual assessment and care plan for 1 of 3 sampled residents (#1) was complete and included the resident's level of functioning who required extensive and/or total assistance with all activities of daily living.

Plan of Correction

To ensure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using the assessment instrument established by the Department, the Resident coordinator will develop a protocol to assure all assessment paper is completed in its entirety. The protocol will involve a checklist to review all paperwork for the admission process. All paperwork will be revised as needed or at least yearly.

Notes-

There was an audit done on all Resident files 1/13/23 to ensure that all correct requirements are up to date. An audit will be performed every 90 days. Resident Coordinator will oversee each audit every 90 days.



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Timeline to complete-

Checklist completed- 2/01/23

Existing residents' assessments completed -1/26/23



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10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service

d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination.

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure 8 ounces of milk was offered or served to the residents twice daily.

Plan of Correction;

To ensure that The Enclave residents' daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day, The Enclave staff will complete a Nutrition and Food Services training provided by Healthcare training company . A state approved Healthcare Training Course to understand the importance of Nutrition and seniors. Also, the Resident Coordinator and Administrator will work in tandem to ensure all staff members understand and follow the proper menu that was curated by the certified nutritionist.

Notes –

There will be quarterly surprise check-ins completed by the House Supervisor to ensure that all nutrition and food services requirements are being followed.

Timeline to complete –

Staff to complete Nutrition and Food Services Training – 1/30/23

Resident Coordinator and Administrator menu training – 1/19/23



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10A NCAC 13G .0904(d)(3)(H) Nutrition and Food Service

(d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages.

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to serve water to residents during the breakfast and lunch meals on 12/20/22.

Plan of Correction;

To ensure that The Enclave resident's Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages, The Enclave staff will complete a Nutrition and Food Services training provided by Healthcare training company. A state approved Healthcare Training Course to understand the importance of Nutrition and seniors. Also, the Resident Coordinator will work with the certified nutritionist to revise The Enclave Menu to include and indicate for each meal to serve water in addition to the residents' beverages.

Notes –

There will be quarterly surprise check-ins completed by the House Supervisor to ensure that all nutrition and food services requirements are being followed.

Timeline to be complete –

Staff to complete Nutrition and Food Services Training – 1/30/23

Revised Menu – 1/12/23

Resident Coordinator and Administrator menu training – 1/19/23



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10A NCAC 13G .1002(a) Medication Orders

10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 sampled residents (#1, #3) for rapid-acting insulin and a medication for seizures (#3) and for a medication used as a sleep aid (#1).

Plan of Correction:

The proper medication administration of each resident is the responsibility of the Resident Coordinator. The Resident Coordinator has completed the proper EMAR training to ensure that all medications are administered as per the doctor's orders. All orders will be checked by the Resident Coordinator before they are placed or submitted on the EMAR. Notifications are sent to the RC with any medications that are missed or late for each resident. Training was completed 1/30/2023. All orders are now faxed to a separate location to ensure that each order is addressed. All the healthcare modalities have been notified of our fax number and also our pharmacies fax number. The prescribers are to fax The Enclave and the contracted pharmacy.



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10A NCAC 13G .1002(a) Medication Orders Cont'd

Notes: The Resident Coordinator will check the fax daily. This is to ensure all orders are correct. If orders need clarification of any kind, before the order is put in the EMAR or the resident is administered their medication; the resident coordinator will contact the physician within 24 hours to ensure that each resident is receiving the proper medication. Monthly audits of the EMAR and medication cart will be performed in conjunction with the Contracted Pharmacy's Quarterly (90 day) Review. All resident admission and readmissions will need to provide medication orders 24 hours prior to being admitted into The Enclave. The Resident Coordinator will ensure that all medication orders are correct, and if needed can be clarified before the admission or readmission of a resident.

Timeline

Resident admission/ readmission procedure- 1/15/23

Resident orders corrected- 12/22/22



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10A NCAC 13G .1004(j) Medication Administration

(j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #3) including inaccurate documentation of a medication for a rapid-acting insulin and a medication for seizures (#3) and a medication for mood disorders (#1).

Plan of Correction:

To ensure each resident's administration record shall be accurate and include, resident's name; name of the medication or treatment order; strength and dosage or quantity of medication administered; instructions for administering the medication or treatment; reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; date and time of administration; documentation of any omission of medications or treatments and the reason for the omission, including refusals; and 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); The Enclave Resident Coordinator develops a protocol to assure all medication is correct and up to date.



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10A NCAC 13G .1004(j) Medication Administration Cont'd

Notes: The Resident Coordinator will check the fax daily. This is to ensure all orders are correct. If orders need clarification of any kind, before the order is put in the EMAR or the resident is administered their medication; the resident coordinator will contact the physician within 24 hours to ensure that each resident is receiving the proper medication. Monthly audits of the EMAR and medication cart will be performed in conjunction with the Contracted Pharmacy's Quarterly (90 day) Review.

Timeline to be complete-

Protocol to be complete and established- 12/22/22



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10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure a physical restraint was used with a written order after an assessment and care planning process had been completed for 1 of 1 sampled resident (#1) with an activity apron tied around the back of the resident's wheelchair preventing the resident from leaning forward and standing up from his wheelchair due to the resident being at risk for falls.



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10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives Cont'd

Plan of Correction-

To ensure that the residents of The Enclave assures that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; the least restrictive restraint that would provide safety; used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; applied correctly according to the manufacturer's instructions and the physician's order; and used in conjunction with alternatives in an effort to reduce restraint use. The Resident Coordinator, the physician and families will work in tandem to ensure that we use the least restrictive method to ensure the safety of each resident. The resident coordinator will develop a policy and procedure that will require both the family and physician to acknowledge different methods of the least restrictive restraint for the resident. The physician will assess and review all documentation regarding the actions and situations that warrant the restraint. The policy and procedure will outline a timeline including: duration, vitals, and mood. This will ensure there is constant communication between all parties. All staff will complete training regarding restraints and must pass exam following training.



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10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives Cont'd

Notes: At the time of a resident restraint The Resident Coordinator, the Physician and the family will be notified prior. The only time restraint is allowed is when there is an emergency, and it is documented in the resident's file and it is agreed upon from the family and the physician; documented through physician orders, behavioral analysis and a care plan.

When a resident is exhibiting any behaviors that are harming to themselves and / other , a restraint warranted. The least resistive restraint can be used to a limited extent only if the reason is fully documented and if their use is subject to a care plan. A House Supervisor must be present at the time of the restraint and document behaviors. The House Supervisor will document range of motion, turning and repositioning, skin assessment, checking the status of any affected areas, and any needs the resident could have physical or psychological.

A restraint flow sheets will be used to document and record the use of restraints, the monitoring of the resident, the care provided and the responses of the resident who is restrained or in seclusion.

Care must be provided as needed to a restrained resident and documented at least every two (2) hours when the person is restrained for behavioral reasons unless the person needs more frequent care. The resident must be release from their restraint every 15 minutes to ensure their safety.

The physician must prescribe a physical restraint to a resident. There must be a written care plan for the use of the physical restraint. The care plan must be developed within 14 days of the device being prescribed, and prior to use on the resident. Every 30 days the resident will be evaluated to validate use of a restraint.



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10A NCAC 13G .1301(a) Use of Physical Restraints and Alternatives Conf'd

Time line to be completed-

Policy and procedure -1/30/23



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G.S. § 131D-45 G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.

Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.

This Rule is not met as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 2 of 3 staff (A, C) sampled who were hired after 10/01/13



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G.S. § 131D-45 G.S. § 131D-45. Cont'd

Plan of Correction:

To ensure examinations and screening for the presence of controlled substances required for applicants for employment in adult care homes; An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. The Enclave has implemented a new protocol at the time of an applicant's interview. The interviewer first discloses that a drug screening must be administered, before an application is started, the interview must have completed drug screen documentation before the application is given. The interviewer must capture a photo of the completed drug screening single use test, the photo will be attached to the disclaimer/ results sheet. The use of the disclaimer sheet alone with the photo of the completed drug test is to document the result and ensure that testing was completed. All current staff will have a current drug screen and single use drug screening device photo.



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G.S. § 131D-45 G.S. § 131D-45. Cont'd

Notes - There was an audit done on all staffing files 1/13/23 to ensure that all correct qualifications were up to date. An audit will be performed every 90 days. The Administrator will oversee each audit every 90 days.

Time to be completed

New Staff protocol - 12/23/22

Existing Staff- 1/13/23