STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 5, 2023.	C 000		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a care plan was completed within 30 days of admission for 3 of 3 sampled residents (#1, #2, and #3). The findings are:	C 231	The administrator and SLC to ensure that care plan is completed within	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 11/6/2023

Reviewed and acknowledged
11/09/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 231	Continued From page 1 1. Review of Resident #1's current FL2 dated 12/06/22 revealed: -Diagnoses included anoxic brain injury, diabetes mellitus, hypertension, and hypercholesterolemia. -Resident #1 was ambulatory. -Resident #1 was continent for bladder and bowel. Review of the Resident Register revealed Resident #1 was admitted on 12/20/22. Review of Resident #1's care plan revealed there was no care plan available to review. Observation of Resident #1 on 10/05/23 at 8:20am, Resident #1 ambulated independently to the dining tablet and ate breakfast unassisted. Interview with Resident #1 at 3:40pm revealed: -He was independent with his activities of daily living. -He did not require assistance except with managing his oral medications. Refer to the interview with the Owner/Administrator on 10/05/23 at 5:40pm. 2. Review of Resident #2's current hospital FL2 dated 02/10/23 revealed: -Diagnoses included chest pain, hypotension, homelessness, diabetes mellitus, and cirrhosis of liver. -Resident #2 was oriented to self, time, situation, and place. -Resident #2 was ambulatory. -Resident #2 was continent for bladder and bowel. Review of the Resident Register revealed Resident #2 was admitted on 01/19/23.	C 231	30 Days of admission in the facility. This process will be monitored by the administrator and reviewed every 2 months.	10/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 231	Continued From page 2 Review of Resident #2's care plan revealed there was no care plan available to review. Observation of Resident #2 on 10/05/23 revealed: -At 8:20am, Resident #2 ambulated independently to the dining tablet and ate breakfast unassisted. -At 9:30am, Resident #2 ambulated independently into the television room, and sat on the couch independently. Interview with Resident #2 at 9:15am revealed: -He was independent with his activities of daily living (bathed himself, dressed himself, and groomed himself). -Staff administered his medications and obtained fingerstick blood sugar checks 4 times a day. Refer to the telephone interview with the primary care Nurse Practitioner (NP) from called placed on 10/05/23 at 4:45pm. Refer to the interview with the Owner/Administrator on 10/05/23 at 5:40pm. 3. Review of Resident #3's current hospital FL2 dated 01/20/23 revealed: -Diagnoses included new onset type 2 diabetes mellitus, essential hypertension, pedestrian injured, and schizophrenia. -Resident #3 was oriented to self, situation, and place. -Resident #3 was independent with ambulation. -Resident #3 was continent for bladder and bowel. -Resident #3 was independent with bathing, feeding, and dressing. Review of the Resident Register revealed	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 231	Continued From page 3 Resident #3 was admitted on 02/03/23. Review of Resident #3's care plan revealed there was no care plan available to review. Observation of Resident #3 on 10/05/23 revealed: -At 8:20am, Resident #3 ambulated independently to the dining tablet and ate breakfast unassisted. -At 9:30am, Resident #3 ambulated independently into the television room, and sat on the couch independently. Interview with Resident #3 at 9:15am revealed: -He was able to manage his own care. (bathed, dressed, and groomed himself). -Staff administered his medications and obtained fingerstick blood sugar checks a couple of times a day. Refer to the telephone interview with the primary care Nurse Practitioner (NP) from called placed on 10/05/23 at 4:45pm. Refer to the interview with the Owner/Administrator on 10/05/23 at 5:40pm. Telephone interview with the primary care Nurse Practitioner (NP) from called placed on 10/05/23 at 4:45pm revealed: -He routinely saw residents at the facility. -He expected the Administrator to prepare any paperwork, care plans or FL2s, and have available for him to review and sign on his routine visits. All the facility needed to do was ask him to sign. -He had not signed any care plans for the residents at the facility recently. Interview with the Owner/Administrator on	C 231		

Reveiwed and acknowledged
11/09/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 231	Continued From page 4 10/05/23 at 5:40pm revealed: -He processed the admissions paperwork for residents. -He was responsible for ensuring that residents' care plan were completed upon admissions and annually. -He had several facilities that he managed the care plans. -He had experienced staff turnovers in his facilities and his focus had been on ensuring staffing of the facilities. -He had not had an opportunity to audit residents' records for completeness of care plans.	C 231		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care referral for 2 of 3 sampled residents (#2 and #3) related to a resident who had an order for a referral for podiatry (#2) and a resident who had a order for a referral for eye care services (#3). The findings are: 1. Review of Resident #2's current FL2 dated 02/10/23 revealed: -Diagnoses included chest pain, hypotension, and diabetes mellitus. -There was an order to check fingerstick blood sugar (FSBS) 4 times a day before meals and at bedtime. -There was an order for twice a day	C 246	The administrator will ensure that all referals are followed through. Eye doctor appointment set for 11/27/23. Podiatry service rendered on 10/20/23. 10/20/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 5 administration of an oral medication to treat diabetics. Review of the Resident Register revealed Resident #2 was admitted on 01/19/23. Review of Resident #2's primary care provider (PCP) physician's progress notes dated 05/11/23 revealed there was an order to refer to podiatrist for evaluation and treatment of toenails. (move this up under the review of the Resident Register) Review of Resident #2's LHPS evaluations revealed: -On 01/20/23, there was a LHPS evaluation with collecting and testing FSBS as a marked task with documentation of fingertips and toes with normal appearance. -On 04/20/23, there was a LHPS evaluation with collecting and testing FSBS as a marked task with documentation of fingertips and toes with normal appearance; FSBS ranged from low 100's to 308 was noted and to complete podiatry visit as scheduled. Review of Resident #2's blood sugar monitoring log dated 09/01/23 to 09/31/23 revealed the resident's blood sugar ranged from 54 to 329 from 09/01/23 to 09/31/23. Review of Resident #2's progress notes revealed there was no documentation for a podiatry evaluation or treatment. Interview with Resident #2 on 10/05/23 at 4:33pm revealed: -Staff checked his blood sugar several times a day. -He had not had any trouble with his toenails or sores on his feet.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 6 Interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 10/05/23 at 4:37pm revealed: -She had been working at the facility since the middle of August 2023. -The Administrator arranged all appointments for the residents. Interview with the Owner/Administrator on 10/05/23 at 5:50pm revealed: -He managed several facilities. -He was responsible for ensuring that orders for referrals were completed. -He routinely used a mobile podiatry service to see residents in all his facilities, including this facility. -He thought Resident #2 was seen by the mobile podiatrist, but he was not able to locate any documentation. Telephone interview with Resident #2's primary care provider (PCP) on 10/05/23 at 4:45pm revealed: -He routinely saw residents at the facility. -The medical practice group he was employed with had a podiatry service available for Resident #2. -He had verbally spoken with the Administrator regarding podiatry services for diabetic residents. -He had not been successful at getting the referral for the podiatry service completed by the facility. -He would like to have diabetic residents, like Resident #2, seen by a podiatrist to ensure there was no issues with their feet since many diabetics have complications with healing of any foot sores. 2. Review of Resident #3's current hospital FL2 dated 01/20/23 revealed diagnoses including new	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 7 onset type 2 diabetes mellitus, and schizophrenia. Review of Resident #3's physicians orders dated 3/16/23 revealed: -There was an order to check fingerstick blood sugar (FSBS) 2 times a day. -There was an order for once a day administration of an oral medication to treat diabetics. Review of the Resident Register revealed Resident #3 was admitted on 02/03/23. Review of Resident #2's primary care provider (PCP) physician's progress notes revealed on 03/16/23, there was an order to refer to a local optometrist for evaluation and treatment. Review of Resident #3's blood sugar monitoring log dated 09/01/23 to 09/31/23 revealed the resident's blood sugar ranged from 65 to 273 from 09/01/23 to 09/31/23. Review of Resident #3's progress notes revealed there was no documentation for an optometrist or ophthalmologist evaluation and treatment available for review. Interview with Resident #3 on 10/05/23 at 4:33pm revealed: -Staff checked his blood sugar every day. -He had not seen a doctor for his eyes. Interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 10/05/23 at 4:37pm revealed: -She had been working at the facility since the middle of August 2023. -The Administrator arranged all appointments for the residents.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 8 Interview with the Owner/Administrator on 10/05/23 at 5:50pm revealed: -He managed several facilities. -He was responsible for ensuring that orders for referrals were completed. -He routinely used a mobile eye care provider service to see residents in all his facilities, including this facility. -He thought Resident #2 was seen by the mobile eye care provider, but he was not able to locate any documentation. Telephone interview with Resident #3's primary care provider (PCP) on 10/05/23 at 4:45pm revealed: -He routinely saw residents at the facility. -He had verbally spoken with the Administrator regarding routine eye care for diabetic residents. -He had not been successful at getting the referral for the eye care provider service for Resident # completed by the facility. -He would like to have diabetic residents, like Resident #2, seen by an eye care provider to ensure there was no issues with their eyes since many diabetics have complications with maintaining good vision and healthy eyes.	C 246		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 254	Continued From page 9 Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluations were completed within 30 days from the date a resident developed the need for the task, and quarterly thereafter for 2 of 3 sampled resident (# 2 and #3) with LHPS tasks of collecting and testing of fingerstick blood sugar (FSBS) samples. The findings are: 1. Review of Resident #2's current FL2 dated 02/10/23 revealed: -Diagnoses included chest pain, hypotension, and diabetes mellitus. -There was an order to check fingerstick blood sugar (FSBS) 4 times a day, before meals and at bedtime. Review of the Resident Register revealed Resident #2 was admitted on 01/19/23.	C 254	The administrator will ensure that admission evaluation is completed within 30 Days of admission into the facility. Also quaterly evaluations are performed without fail by the Group RN. 10/10/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 254	Continued From page 10 Review of Resident #2's LHPS evaluations revealed: -On 01/20/23, there was a LHPS evaluation with collecting and testing FSBS as a marked task and fingertips and toes with normal appearance. -On 04/20/23, there was a LHPS evaluation with collecting and testing FSBS as a markedtask and fingertips and toes with normal appearance. -There was no subsequent quarterly LHPS evaluation available for review. Review of Resident #2's August 2023, September 2023 and October 2023 medication administration records (MARs) revealed there was documentation for FSBS values were obtained 4 times a day from 08/01/23 to 10/04/23. Interview with Resident #2 at 9:15am revealed staff routinely administered his medications and obtained fingerstick blood sugar checks 4 times a day. Attempted telephone interview with the contracted LHPS Nurse on 10/05/23 at 5:00pm was unsuccessful. Refer to the interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 10/05/23 at 2:31pm. Refer to the interview with the Owner/Administrator on 10/05/23 at 5:15pm. 2. Review of Resident #3's current hospital FL2 dated 01/20/23 revealed diagnoses included new onset type 2 diabetes mellitus, and schizophrenia. Review of the Resident Register revealed Resident #3 was admitted on 02/03/23.	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 254	Continued From page 11 Review of Resident #3's physicians orders dated 3/16/23 revealed there was an order to check fingerstick blood sugar (FSBS) 2 times a day. Review of Resident #3's LHPS evaluations revealed: -On 02/03/23, there was a LHPS evaluation with collecting and testing FSBS as a marked task and fingertips and toes with normal appearance. -On 05/03/23, there was a LHPS evaluation with collecting and testing FSBS as a marked task and fingertips and toes with normal appearance. -There was no subsequent quarterly LHPS evaluation available for review. Review of Resident #3's August 2023, September 2023, and October 2023 medication administration records (MARs) revealed there was documentation for FSBS values were obtained 2 times a day from 08/01/23 to 10/04/23. Interview with Resident #3 at 4:00pm revealed staff routinely administered his medications and obtained fingerstick blood sugar checks a couple of times a day. Attempted telephone interview with the contracted LHPS Nurse on 10/05/23 at 5:00pm was unsuccessful. Refer to the interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 10/05/23 at 2:31pm. Refer to the interview with the Owner/Administrator on 10/05/23 at 5:15pm. Interview with the MA/SIC on 10/05/23 at 2:31pm revealed:	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 254	Continued From page 12 -She did not know the requirements for LHPS evaluations. -The facility had a contracted Nurse that completed LHPS evaluations. -The Administrator kept the LHPS paperwork if it was not in the record. -The Administrator was responsible for tracking the LHPS evaluations and scheduled the LHPS nurse to complete LHPS evaluations. Interview with the Owner/Administrator on 10/05/23 at 5:15pm revealed: -He contracted a LHPS Nurse to complete residents LHPS evaluations quarterly. -The LHPS Nurse was supposed to track the LHPS evaluations regarding when a quarterly LHPS evaluation was due for each resident. -He did not have a system in place to routinely audit residents' LHPS evaluations for timeliness. -The Administrator was responsible for ensuring LHPS evaluations were done quarterly. -He did not know the contracted LHPS Nurse had not completed quarterly LHPS reviews for all residents.	C 254	Administrator and RN have a routine in place to ensure that LHPS evaluations are always done on time every quarter. Administrator to monitor this process every quarter.	10/20/23
C 291	10A NCAC 13G .0905 (c) Activities Program 10A NCAC 13G .0905 Activities Program (c) The activity director shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities, and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities in a format that is legible and shall be posted in a location accessible to residents by the	C 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 291	Continued From page 13 first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, and religious organizations, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are supplies necessary for planned activities, supervision, and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a monthly calendar of planned group activities, encourage resident participation in activities and have supplies available for planned group activities for the 5 residents residing at the facility. The findings are: Observations during the facility tour on 10/05/23, and at 5:00pm on 10/05/23 revealed: -There was a September 2023 activity calendar posted on the dining room wall. -There was no activity calendar posted for October 2023. -There were a few boxes for board games on a	C 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 291	Continued From page 14 shelf in he hallway leading from the sitting area to back bedrooms. Interview with 2 residents on 10/05/23 at 3:40pm revealed: -The activity calendar in the dining room was for last month (September 2023). -They did not routinely have activities that were included on the calendar. -"Once in a while, the staff play a game". -"Mostly we sit around and look at each other or watch TV (television)". Interview with the Administrator on 10/05/23 at 5:00pm revealed: -He was responsible to create and post the activity calendar monthly. -He had a calendar in his car, but he had not brought it into the facility. -The residents often refused to participate in activities when asked. -The medication aide/Supervisor-in-Charge (MA/SIC) was responsible to ensure activities were done with the residents or at least attempted to be done even if residents refused.	C 291	The administrator will ensure that staff are coordinating activities to be done daily. Log of residents who refuse to do activities will always be up to date.	10/10/23
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	C 330	Administrator will ensure that activity calender is posted on the 1st of each month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 15 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered to 3 of 3 sampled residents (#1, #2, and #3) related to a medication to treat diabetes (#1), a pancreatic enzyme supplement (#2), and a topical pain reliever cream (#3). The findings are: 1. Review of Resident #1's current FL2 dated 12/06/22 revealed: -Diagnoses included anoxic brain injury, diabetes mellitus, hypertension, and hypercholesterolemia. -There was an order for Januvia 100mg (used to treat elevated blood sugar) once daily. Review of Resident #1's physicians orders revealed there was no order to hold or discontinue administration of Januvia 100mg available for review. Review of Resident #1's September 2023 medication administration record (MAR) revealed: -There was an entry for Januvia 100mg every morning, scheduled for administration at 8:00am. -There was documentation Januvia 100mg was not administered from 09/01/23 to 09/31/23 (all days were blank on the MAR). Review of Resident #1's October 2023 MAR from 10/01/23 to 10/05/23 revealed: -There was an entry for Januvia 100mg every morning, scheduled for administration at 8:00am. -There was documentation Januvia 100mg was not administered from 10/01/23 to 10/05/23 (all days were blank on the MAR). Review of Resident #3's blood sugar monitoring	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 16 log dated 09/01/23 to 10/05/23 revealed: -Resident #1 had documented blood sugar value twice a day. -The resident's blood sugar ranged from 88 to 358 from 09/01/23 to 10/05/23. Observation of medication on hand for administration to Resident #1 on 10/05/23 at 2:30pm revealed: -Resident #1's morning medications were packaged together in a multidose bubble pack with all morning medications in one bubble and labeled for the day of the month. -The morning medication bubble packs were in a "yellow" plastic holder which represented medications for administration in the morning. (Blue holders were for nighttime administration). -There were multidose bubbles dated from 09/23/23 to 10/15/23 with empty multidose bubble from 09/23/23 through 10/05/23. -There were 5 medications in the multidose bubble for morning administration. -There was no Januvia 100mg included in medications packaged in the morning multidose bubble. Telephone interview with a pharmacist at the contracted pharmacy provider on 10/05/23 at 3:05pm revealed: -The pharmacy routinely packaged the residents' medications in the multidose bubble packs for one 4 weeks at a time on the plastic bubble package holders with weekly rows beginning on Saturday and ending on Friday. -The pharmacy sent Januvia in multidose bubble packages for August 2023. -The resident had a large outstanding billing balance for Januvia 100mg copays. -The pharmacy's routine procedure was to notify the facility anytime a medication was packaged	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 17 as ordered in the multidose bubble packages. -The Owner/Administrator was notified of the pharmacy not sending any more Januvia 100mg until payment was received toward Resident #1's balance due in September 2023. -No Januvia was dispensed for September 2023 or October 2023 awaiting the Owner/Administrator's response. -There had been no response to the pharmacy by the Owner/Administrator. Interview with Resident #1 on 10/05/23 at 5:15pm revealed: -He did not realize he was missing one of his medications. -He did not know all his medications. -His blood sugar was sometime high and sometimes low when taken. -He had not noticed any change in the way he felt over the last couple of months. Interview with the Owner/Administrator on 10/05/23 at 5:35pm revealed: -He knew Resident #1 was not receiving Januvia 100mg in his medication in September 2023 and October 2023. -The resident did not have money to pay the pharmacy bill. -The Owner/Administrator said he had reached out to Resident #1's primary care Nurse Practitioner to let him know the resident could not afford Januvia 100mg. -The NP would have to decide what Resident #1 should do regarding the Januvia 100mg. -He did not have documentation available for review for notifying the NP. Telephone interview with the primary care Nurse Practitioner (NP) from called placed on 10/05/23 at 4:45pm revealed:	C 330	Resident #1 primary Care has discharged Januvia 100mg. Administrator to ensure that any issues regarding affordability of medications are	10/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 18 -He routinely saw residents at the facility. -He expected medications to be administered as ordered. -He did not know Resident #1's Januvia 100mg was not included in his daily medications. -He would try to work with a resident's medications if he was made aware of financial limitations. 2. Review of Resident #2's current FL2 dated 02/10/23 revealed: -Diagnoses included chest pain, hypotension, homelessness, and diabetes mellitus. -There was an order Creon (a supplement for pancreatic enzymes) one capsule 3 times a day with meals. Review of Resident #2's physicians orders revealed there was no order to hold or discontinue administration of Creon for review. Review of Resident #2's September 2023 medication administration record (MAR) revealed: -There was an entry for Creon capsule every morning, scheduled for administration at 8:00am, 12:00pm(noon) and 5:00pm. -There was documentation Creon was administered 3 times a day from 09/01/23 to 09/10/23. -There was no administration documented from 09/11/23 to 09/31/23 (all days were blank on the MAR). Review of Resident #2's October 2023 MAR from 10/01/23 to 10/05/23 revealed: --There was an entry for Creon capsule every morning, scheduled for administration at 8:00am, 12:00pm(noon) and 5:00pm. -There was documentation Creon was administered 3 times daily on 10/01/23 and	C 330	always documented and resolved with the primary care very quickly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 19 10/02/23. -There was no documentation Creon was administered from 10/03/23 to 10/05/23 (all days were blank on the MAR). Observation of medication on hand for administration to Resident #2 on 10/05/23 at 2:30pm revealed: -Resident #2's morning medications were packaged together in multidose bubble packs with all morning medications in two bubbles and labeled for the day of the month. -The morning medication bubble packs were in a "yellow" plastic holder which represented medications for administration in the morning. (Blue holders were for nighttime administration). -There were 2 multidose bubbles dated from 09/19/23 to 10/18/23 with empty multidose bubbles from 09/19/23 through 10/05/23. -There were 9 medications in 2 multidose bubbles for morning administration. -There was no Creon included in medications packaged in the morning multidose bubble. -There was no Creon available for administration to Resident #2 Telephone interview with a pharmacist at the contracted pharmacy provider on 10/05/23 at 3:05pm revealed: -The pharmacy routinely packaged the residents' medications in the multidose bubble packs for one 4 weeks at a time on the plastic bubble package holders with weekly rows beginning on Saturday and ending on Friday. -The pharmacy sent Creon in multidose bubble packages for August 2023 for a quantity sufficient that would have ended on 09/10/23. -The resident had a large outstanding billing balance for Creon copays. -The pharmacy's routine procedure was to notify	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 20	C 330		

the facility anytime a medication was packaged as ordered in the multidose bubble packages.
-The Owner/Administrator was notified of the pharmacy not sending any more Creon until payment was received toward Resident #2's balance due in September 2023.
-No Creon was dispensed for Resident #2 in September 2023 or October 2023 awaiting the Owner/Administrator's response.
-There had been no response to the pharmacy by the Owner/Administrator.

Interview with Resident #2 on 10/05/23 at 4:55pm revealed:
-He did not realize he was missing one of his medications.
-He did not know all his medications.
-He had not had any stomach pain recently.

Interview with the Owner/Administrator on 10/05/23 at 5:35pm revealed:
-He knew Resident #2 was not receiving Creon in his medication in September 2023 and October 2023.
-The resident did not have money to pay the pharmacy bill.
-The Owner/Administrator said he had reached out to Resident #2's primary care Nurse Practitioner to let him know the resident could not afford Creon.
-The NP would have to decide what Resident #1 should do regarding Creon.
-He did not have documentation available for review for notifying the NP of missed Creon.

Telephone interview with the primary care Nurse Practitioner (NP) from called placed on 10/05/23 at 4:45pm revealed:
-He routinely saw residents at the facility.
-He expected medications to be administered as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 21 ordered. -He did not know Resident #2's Creon was not included in his daily medications. -Resident #2 had a history of occasional flare-ups of pancreatitis. The enzymes in Creon were supposed to help prevent acute flare-up of pancreatitis. -He had been requested a document to be signed by Resident #2 stating he was not going to take Creon, however the Owner/Administrator had not sent the document back to him as requested. He had not discontinued Creon capsules. 3. Review of Resident #3's current hospital FL2 dated 01/20/23 revealed: -Diagnoses included new onset type 2 diabetes mellitus, and schizophrenia. -There was an order for diclofenac 1% (a topical pain reliever cream) apply 4 grams topically 4 times day. Review of Resident #3's September 2023 medication administration record (MAR) revealed: -There was an entry for diclofenac 1% apply 4 grams 4 times a day, scheduled for application at 8:00am, 12:00pm(noon) 4:00pm, and 8:00pm. -There was documentation diclofenac 1% cream was applied 4 times a day from 09/01/23 to 09/31/23. Review of Resident #2's October 2023 MAR from 10/01/23 to 10/05/23 revealed: -There was an entry for diclofenac 1% apply 4 grams 4 times a day, scheduled for application at 8:00am, 12:00pm(noon) 4:00pm, and 8:00pm. -There was documentation diclofenac 1% cream was not applied 4 times a day from 10/01/23 to 10/04/23 (the MAR was blank for administration). Observation of medication on hand for	C 330	The guardian of resident #2 was again contacted about the need to pay $93 each month for this medication. The guardian said he cannot pay for this medication. The administrator has paid for the medication to be delivered and the resident is taking Creon daily. 10/17/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 22 administration to Resident #3 on 10/05/23 at 2:50pm revealed: -Resident #3 had a 100 gram tube of diclofenac 1% cream labeled apply 4 grams four times a day with a dispensed date of 04/23/23 on the tube. -The tube was opened but appeared almost full. -There was no additional diclofenac 1% cream in Resident #3's medications on hand for administration. Telephone interview with a pharmacist at the contracted pharmacy provider on 10/05/23 at 3:05pm revealed: -The pharmacy had a current order for diclofenac 1% cream 4 grams 4 times a day dated 04/03/23. -The pharmacy dispensed 100 gm (50 doses) of diclofenac 1% cream on 04/23/23 but no additional cream had been dispensed. -The facility had to request refills when needed for topical medications; topicals were not cycle filled. Interview with Resident #3 on 10/05/23 at 5:00pm revealed: -He did not routinely receive a topical cream for joint pain. -He had not asked for a topical pain cream because he did not need it. Interview with the medication aide/Supervisor-in-Charge (MA/SIC) on 10/05/23 at 5:10pm revealed: -She had been working at the facility since late August 2023. -She worked most of the time. -Resident #3 did not want his diclofenac 1% cream applied. -Resident #3 did not ask for his diclofenac 1% cream. -She did not know why she documented	C 330	Order has been changed to as needed basis for diclofenac. Administrator and SIC to ensure that any creams or lotions which are not needed is communicated to the PCP so that either they are discharged or order changed to as needed.	10/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 23 application of the cream on the MARs every day. Interview with the Owner/Administrator on 10/05/23 at 5:35pm revealed: -He was responsible for ensuring medications were administered as ordered. -He had a lot of facilities to manage and had not had an opportunity to review residents' records for medication orders compared to MAR documentation. Telephone interview with the primary care Nurse Practitioner (NP) from called placed on 10/05/23 at 4:45pm revealed: -He routinely saw residents at the facility. -He expected medications to be administered as ordered.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container;	C 335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 335	Continued From page 24 (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the resident's name and the name and strength of each medication prepared, and protected from contamination and spillage for 1 of 1 residents (#1) including a medication for elevated triglycerides, a medication for diabetes, blood pressure medications, and a medication for for gastric reflux. The findings are: Review of Resident #1's current FL2 dated 12/06/22 revealed: -Diagnoses included anoxic brain injury, diabetes mellitus, hypertension, and hypercholesterolemia. -There was an order for fenofibrate (used to treat elevated cholesterol and triglycerides) 54mg daily.	C 335	The care giver has been retrained that prepouring is not allowed. The administrator will do spot checks every other month to ensure that prepouring is not happening and med administration protocols are being maintained. 10/7/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 335	Continued From page 25 -There was an order for lisinopril (used to treat high blood pressure) 20mg daily. -There was an order for nifedipine (used to treat high blood pressure) extended release (ER) 30mg once daily. Review of Resident #1's physician's orders revealed: -On 05/11/23, there was an order for glimepiride (used to treat diabetes) 4mg take 2 tablets daily. -On 06/09/23, there was an order for pantoprazole (used to treat gastric reflux) 40mg daily. Observation of the facility on 10/05/23 during the initial tour revealed: -At 8:08am, there were three residents seated at the dining room table for breakfast; the medication aide/Supervisor-in-Charge (MA/SIC) was preparing breakfast in the kitchen area. -There was a medication room/staff bedroom/office area adjoining the kitchen. -At 8:14am, there was a pre-poured clear medication cup with 6 oral medications sitting on top of the medication cart. The cup was placed on top of a note with a resident's name written on the note. The cup was not covered and was not labeled with the name of the medication, resident's name or time for administration. -At 8:16am, the MA/SIC took the medication cup to the dining table and sat the medication cup in front of a resident (#1), turned and walked back into the kitchen area to continue preparing breakfast plates. Review of Resident #1's October 2023 medication administration record (MAR) from 10/01/23 to 10/05/23 to at 8:27am revealed: -There was an entry for fenofibrate 54mg daily scheduled for administration at 8:00am; there	C 335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 335	Continued From page 26 was no documentation for administration on 10/05/23 at 8:00am. -There was an entry for lisinopril 20mg daily scheduled for administration at 8:00am; there was no documentation for administration on 10/05/23 at 8:00am. -There was an entry for nifedipine ER 30mg once daily scheduled for administration at 8:00am; there was no documentation for administration on 10/05/23 at 8:00am. -There was an entry for glimepiride 4mg take 2 tablets daily with breakfast or first main meal scheduled for administration at 8:00am; there was no documentation for administration on 10/05/23 at 8:00am. -There was an entry for pantoprazole 40mg daily. Observation of Resident #1's medications on hand on 10/05/23 at 11:14am revealed: -Resident #1's medications were dispensed in multidose bubble packages. -Each bubble listed the medications, the administration time, and the administration date. -The 8:00am medications for 10/05/23 (fenofibrate 54mg, lisinopril 20mg, nifedipine ER 30mg, 2 tablets of glimepiride 4mg, and pantoprazole 40mg) had been punched from the bubble. Interview with the Medication Aide (MA) on 10/05/23 at 12:03pm revealed: -She prepared the residents' medications before she she started cooking breakfast because she was very busy when she prepared and plated breakfast and did not want to make residents wait for their medications. -She waited until the resident was seated and then placed each resident's medications in front of them. -She was trained to prepare medications one	C 335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 335	Continued From page 27 resident at a time, administer the medication, then document on the MAR before going to the next resident. Interview with the Administrator on 10/05/23 at 5:50pm revealed: -The contracted pharmacy sent residents' medications in multidose bubble packages to help minimize the time needed to prepare medications for administration. -The MAs were trained to prepare medications one resident at a time, administer the medication, and then document on the resident's MAR. -The MA were not supposed to prepare medications in advance. -He had not looked at the MAR for the residents in a few weeks; he looked for "holes" in the MAR when he audited the MARs.	C 335		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 341	Continued From page 28 documentation on medication administration record by the staff person who administered the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication for 1 of 1 residents (#1) including a cholesterol medication, a blood sugar lowering medication, blood pressure medications, and a medication for gastric reflux. The findings are: Review of Resident #1's current FL2 dated 12/06/22 revealed: -Diagnoses included anoxic brain injury, diabetes mellitus, hypertension, and hypercholesterolemia. -There was an order for fenofibrate (used to treat elevated cholesterol and triglycerides) 54mg daily. -There was an order for lisinopril (used to treat high blood pressure) 20mg daily. -There was an order for nifedipine (used to treat high blood pressure) extended release (ER) 30mg once daily. Review of Resident #1's physician's orders revealed: -On 05/11/23, there was an order for glimepiride (used to treat diabetes) 4mg take 2 tablets daily. -On 06/09/23, there was an order for pantoprazole (used to treat gastric reflux) 40mg daily. Observation of the facility on 10/05/23 during the initial tour revealed: -At 8:08am, there were three residents seated at the dining room table for breakfast; the medication aide/Supervisor-in-Charge (MA/SIC) was preparing breakfast in the kitchen area. -There was a medication room/staff	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 341	Continued From page 29 bedroom/office area adjoining the kitchen. -At 8:14am, there was a pre-poured clear medication cup with 6 oral medications sitting on top of the medication cart. The cup was placed on top of a note with a resident's name written on the note. The cup was not covered and was not labeled with the name of the medication, resident's name or time for administration. -At 8:16am, the MA/SIC took the medication cup to the dining table and sat the medication cup in front of a resident (#1), turned and walked back into the kitchen area to continue preparing breakfast plates. -She did not observe the resident take the morning medications. -She did not have medication administration records (MAR) at the table. -She did not document on the MARs for the resident. Review of Resident #1's October 2023 medication administration record (MAR) from 10/01/23 to 10/05/23 to at 8:27am revealed: -There was an entry for fenofibrate 54mg daily scheduled for administration at 8:00am; there was no documentation for administration on 10/05/23 at 8:00am. -There was an entry for lisinopril 20mg daily scheduled for administration at 8:00am; there was no documentation for administration on 10/05/23 at 8:00am. -There was an entry for nifedipine ER 30mg once daily scheduled for administration at 8:00am; there was no documentation for administration on 10/05/23 at 8:00am. -There was an entry for glimepiride 4mg take 2 tablets daily with breakfast or first main meal scheduled for administration at 8:00am; there was no documentation for administration on 10/05/23 at 8:00am.	C 341	Caregiver has been retrained to watch the resident swallow the medication before she turns away as per the guidelines for effective medication administration.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 341	Continued From page 30 -There was an entry for pantoprazole 40mg daily. Observation of Resident #1's medications on hand on 10/05/23 at 11:14am revealed: -Resident #1's medications were dispensed in multidose bubble packages. -Each bubble listed the medications, the administration time, and the administration date. -The 8:00am medications for 10/05/23 (fenofibrate 54mg, lisinopril 20mg, nifedipine ER 30mg, 2 tablets of glimepiride 4mg, and pantoprazole 40mg) had been punched from the bubble. Interview with the Medication Aide (MA) on 10/05/23 at 12:03pm revealed: -She waited until the resident was seated and then placed their medications in front of them. -She did not document medication administration on the MAR after administering each resident their medication one at a time because she was busy preparing breakfast and plating breakfast and did not want to make residents wait for their medications. -She was trained to prepare medications one resident at a time, administer the medication, then document on the MAR before going to the next resident. Interview with the Administrator on 10/05/23 at 5:50pm revealed: -The MAs were trained to punch one medication from the card at a time and then to document on the MAR. -They were to compare the medication in the card to the MAR prior to punching the card. -They were to watch the resident swallow the medication and then document on the MAR after each administration. -The MA were supposed to have the MAR with	C 341	The caregiver has been retrained on the importance of documenting after each residents meds have been administered. This is being monitored by the administrator on a monthly basis 10/1/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 341	Continued From page 31 them while administering the medications. -He had not looked at the MAR for the residents in a few weeks; he looked for "holes" in the MAR when he audited the MARs.	C 341		
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications. This Rule is not met as evidenced by: Based on interviews, record reviews and observations, the facility failed to ensure an assessment and physician's order was in place	C 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 350	Continued From page 32 for 1 of 3 sampled residents (#1) who self-administered fingerstik blood sugar (FSBS) checks. The findings are: Review of Resident #1's current FL2 dated 12/06/22 revealed: -Diagnoses included anoxic brain injury, diabetes mellitus, hypertension, and hypercholesterolemia. -There was an order for fingerstick (FSBS) twice a day. -There was no order to self administer FSBS on the FL2 Review of Resident #1's care plan revealed there was no care plan to review. Review of Resident #1's physicians orders from 12/06/22 to 10/05/23 revealed there was no order to self administer FSBS checks. Review of Resident #1's assessments revealed there was no assessment for Resident #1's self administration of FSBS. Observation of the dining tablet on 10/05/23 at 8:15am revealed: -Resident #1 was seated at one end of the dining table toward the back deck. -Directly in front of Resident #1 was a clear plastic zip-loc bag containing a glucometer (device for check blood sugar levels), disposable lancets, and alcohol swabs. -There was no staff in the dining room and 2 other residents were seated at the table. Interview with Resident # 1 on 10/05/23 at 8:15am revealed: -He was waiting for breakfast to be served.	C 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 350	Continued From page 33 -The medication aide/Supervisor-in-Charge (MA/SIC)) placed the zip-lock bag at his assigned seat every morning. -The MA stored his glucometer and supplies in the medication room and brought them to the tablet in the morning. -He routinely took his own FSBS reading and reported it to the medication aide in he mornings and in the evenings. -He did not know if there was an order for him to self administer his insulin. Inteview with the MA/SIC on 10/05/23 at 5:35pm revealed: -She routinely observered Resident #1 when he obtained his FSBS. Resident #1's glucometer and insulin was kept in the medication room and delivered to the resident when it was ordered (8:00am and 8:00pm) on the MAR. -Resident #1 obtained his own FSBS dailt when she worked. -She did not know if Resident #1 had an order to self administer FSBS. Interview with the Owner/Administrator on 10/05/23 at 5:40pm revealed: -He did not know Resident #1 was administering his own insulin and obtaining his own FSBS. -Resident #1 did not have an order to self administer insulin or to obtain his own FSBS. -The MA/SIC should not be allowing the resident to self administer even if he told the MA what his FSBS value was when obtained.	C 350	Resident #1 does not have an order for self administration. 10/7/23 Caregivers are doing the FSBS checks going forward and recording the figures.	
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a	C 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 375	Continued From page 34 licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmaceutical reviews were completed for 3 of 3 sampled residents (#1, #2, and #3). The findings are:	C 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 375	Continued From page 35 1. Review of Resident #1's current FL2 dated 12/06/22 revealed diagnoses included anoxic brain injury, diabetes mellitus, hypertension, and hypercholesterolemia. Review of the Resident Register revealed Resident #1 was admitted on 12/20/22. Review of Resident #1's pharmacy reviews revealed: -There was a completed pharmacy review dated 05/10/23. -There were no subsequent pharmacy reviews available for review. Interview with the Owner/Administrator on 10/05/23 at 4:05pm revealed: -He did not know Resident #1 did not have quarterly pharmacy reviews completed. -He had so many other things to do running his facilities, he had overlooked calling the pharmacy to arrange their medication review service. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 10/05/23 at 4:25pm. Refer to the interview with the Owner/Administrator on 10/05/23 at 5:50pm. 2. Review of Resident #2's current FL2 dated 02/10/23 revealed diagnoses included chest pain, hypotension, homelessness, and diabetes mellitus. Review of the Resident Register revealed Resident #2 was admitted on 01/19/23. Review of Resident #2's pharmacy reviews	C 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 375	Continued From page 36	C 375		

revealed:
-There was a completed pharmacy review dated 05/10/23.
-There were no subsequent pharmacy reviews available for review.

Interview with the Owner/Administrator on 10/05/23 at 4:05pm revealed:
-He did not know that Resident #2 did not have quarterly pharmacy reviews completed.
-He had so many other things to do running his facilities, he had overlooked calling the pharmacy to arrange their medication review service.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 10/05/23 at 4:25pm.

Refer to the interview with the Owner/Administrator on 10/05/23 at 5:50pm.

3. Review of Resident #3's current hospital FL2 dated 01/20/23 revealed diagnoses included new onset type 2 diabetes mellitus, and schizophrenia.

Review of the Resident Register revealed Resident #3 was admitted on 02/03/23.

Review of Resident #3's pharmacy reviews revealed:
-There was a completed pharmacy review dated 05/10/23.
-There were no subsequent pharmacy reviews available for review.

Interview with the Administrator/Owner on 10/05/23 at 4:05pm revealed:
-He did not know that Resident #3 did not have quarterly pharmacy reviews completed.
-He had so many other things to do to running his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 375	Continued From page 37 facilities, he had overlooked calling the pharmacy to arrange their medication review service. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 10/05/23 at 4:25pm. Refer to the interview with the Owner/Administrator on 10/05/23 at 5:50pm. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/05/23 at 4:25pm revealed: -The pharmacy was contracted for dispensing medications to the facility. -The pharmacist routinely completed quarterly medication reviews for facilities if they requested the service. -The Administrator had requested to be at the facility when quarterly medication reviews were conducted to provide access to medication administration records (MARs), unfiled medication orders and laboratory results, or miscellaneous information that may be needed for the review. -The pharmacist had attempted unsuccessfully several times to arrange a time that the Administrator would meet her at the facility. -They did not complete quarterly pharmacy medication reviews for the facility because the Administrator had not arranged a time for her to come to the facility. Interview with the Owner/Administrator on 10/05/23 at 6:15pm revealed: -He was responsible for ensuring each resident had a quarterly pharmacy review. -He had not done an audit of the resident records recently. -He expected the contracted pharmacy to provide	C 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl041077	A. BUILDING: _____ B. WING _____	10/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EL BETHEL FAMILY CARE HOME	204 CIRCLE DRIVE GIBSONVILLE, NC 27249

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 375	Continued From page 38 quarterly medication reviews for the residents. -He did not recall when the contracted pharmacist last contacted him to schedule the quarterly pharmacy review.	C 375	Pharmacy Reviews are being conducted quarterly and the administrator and RN will ensure that this is being done every 3 months.	10/5/23