STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032062	A. BUILDING: _____ B. WING _____	09/11/2024

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

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 11, 2024.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure medications were administered as ordered for 1 of 2 sampled residents (#1) related to a medication for headaches, and 2 medications for constipation. The findings are: Review of Resident #1's current FL2 dated 08/04/23 revealed diagnoses included schizophrenia, atrial fibrillation, and Crohn's disease. a. Review of Resident #1's current FL2 dated 08/04/23 revealed an order for verapamil (used to reduce frequency and duration of headaches) 80mg take one-half tablet 3 times a day. Review of Resident #1's physician's orders dated 08/29/24 revealed an order to discontinue verapamil 80mg one-half tablet 3 times a day,	C 330		

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C 330	Continued From page 1 start verapamil 120mg Extended Release (ER) one tablet daily. Observation of medication administration on 09/11/24 at 8:25am revealed Resident #1 was administered 5 oral medications including one verapamil 120mg. Observation of medication on hand for administration to Resident #1 on 09/11/24 revealed: -There was a partial bottle of verapamil 80mg labeled one-half tablet 3 times a day dispensed on 03/22/24. -There was a bottle of verapamil 120mg ER tablets labeled on tablet daily for migraine prevention dispensed on 09/04/24 for 90 tablets with 86 tablets remaining. Review of Resident #1's August 2024 medication administration record (MAR) revealed: -There was a handwritten entry for verapamil 80mg one three times a day scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -Verapamil 80mg was documented administered 3 times a day from 08/01/24 to 08/31/24. Review of Resident #1's September 2024 MAR from 09/01/24 to 09/11/24 revealed: -There was no entry for verapamil 80mg one-half tablet 3 times a day. -There was no documentation verapamil 80mg one-half tablet 3 times a day was administered in September 2024. -There was a handwritten entry for verapamil ER 120mg one tablet daily for migraine prevention. -Verapamil 120mg ER was blank for scheduled time of administration and marked out for documentation as not administered from 09/01/24 to 09/07/24.	C 330		

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C 330	Continued From page 2 -Verapamil 120mg ER was documented as administered daily from 09/08/24 to 09/11/24. Interview with the medication aide/Supervisor in Charge (MA/SIC) on 09/11/24 at 11:30am revealed: -Resident #1's medications, including verapamil 120mg ER, were received via mail from the Veteran's Administration (VA) pharmacy directly to the resident at the facility. -Resident #1 routinely received his medications via United States Postal Service mail 3-5 days after the medication was ordered. -Resident #1 did not receive verapamil 120mg until mail delivery on 09/07/24. -She thought she had handwritten verapamil 80 mg one-half tablet 3 times a day on a separate MAR page for September 2024 and administered on from 09/01/24 to 09/07/24. -There was no documented administration of verapamil 80mg (one-half tablet) or verapamil ER 120mg from 09/01/24 to 09/07/24. Interview with Resident #1's primary care provider (PCP) on 09/11/24 at 2:30pm revealed: -Resident #1 had a visit in August 2024 to the clinic. -Resident #1 was ordered verapamil to help decrease migraine headaches. -The PCP changed verapamil 80mg one-half tablet 3 times a day (equals 120mg total) to verapamil 120 mg ER once daily for the resident to have the same dose with less medication tablets to be administered daily. -If Resident #1 had missed a few doses of verapamil he may have had a migraine headache but no major side effects from missed doses. Interview with Resident #1 on 09/11/24 at 3:30pm revealed:	C 330		

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C 330	Continued From page 3	C 330		

-He received his medications this morning.
-He did not know all his medications by name because sometimes the medications changed.
-He did not know if he received verapamil 80mg one-half tablet from 09/091/24 to 09/07/24 because that was several days ago.
-He had headaches in the past but had not had a headache within the last few weeks.

Interview with the facility's Manager on 09/11/24 at 4:45pm revealed:
-She reviewed Resident #1's September MAR at the beginning of September 2024.
-She did not recall Resident #1's verapamil order changing and was not aware there was no documented administration for verapamil from 09/01/24 to 09/07/24.

Attempted telephone with the Administrator on 09/11/24 at 5:00pm was unsuccessful.

Refer to the interview with the medication aide/Supervisor in Charge (MA/SIC) on 09/11/24 at 11:30am.

Refer to the interview with the facility's Manager on 09/11/24 at 4:45pm.

b. Review of Resident #1's current FL2 dated 08/04/23 revealed an order for polyethylene glycol (PEG) 3350 oral powder one-half capful mixed in water and taken every day for constipation.

Review of Resident #1's physician's order from a gastro-intestinal (GI) clinic follow-up for Crohn's disease dated 04/05/24 revealed recommendation for stopping PEG.

Review of Resident #1's medication list summary from the primary care provider (PCP) dated

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C 330	Continued From page 4 06/13/24 revealed an order for PEG mix one-half capful in water every day for constipation. Telephone interview with Resident #1's PCP on 09/11/24 at 2:30pm revealed: -Resident #1 visited the VA clinical services for his medical care. -Resident #1 had trouble with chronic constipation and lower gastro-intestinal irritation. -Resident #1 would benefit from regularly scheduled treatment of constipation. -Resident #1 should be administered PEG 3350 routinely unless the resident complained of diarrhea. -The VA clinic maintained a list of medications ordered that included a coordination of orders between the various clinics seen for VA services and was reviewed and updated with each provider's visit. -The medications listed on the visit summary medication list should be considered a comprehensive list of current medications. -The facility should be administering medications as ordered on the medications listed on the office visit summaries. -PEG was listed as a current medication and should be administered as ordered. Observation of Resident #1's medications on hand for administration on 09/11/24 revealed: -There was a partial container of PEG 3350 oral powder dispensed for 510 grams on 03/05/24. -There was an unopened container of PEG 3350 oral powder dispensed for 510 grams on 08/30/24. Review of Resident #1's June 2024 MAR revealed: -There was a handwritten entry for polyethylene glycol 3350 oral powder mix 8.5 grams (one-half	C 330		

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capful) in water every day for constipation.
-There was no scheduled time for administration and no documented administration of PEG 3350 in June 2024.

Review of Resident #1's July 2024, August 2024, and September 2024 (from 09/01/24 to 09/11/24) MARs revealed:
-There was no entry for polyethylene glycol 3350 oral powder mix 8.5 grams (one-half capful) in water every day for constipation.
-There was no documentation polyethylene glycol 3350 oral powder was administered in July 2024, August 2024 or September 2024 from 09/01/24 to 09/11/24.

Interview with the MA/SIC on 09/11/24 at 11:30am revealed:
-Resident #1 had an adequate supply of PEG on hand for administration.
-Resident #1's order for PEG 3350 daily was on the June 2024 MAR but there was no documentation Resident #1 received PEG.
-She did not know why she left off the entry for PEG on the July 2024, August 2024, and September 2004 MARs.
-She thought Resident #1 had an order to change PEG 3350 to as needed instead of daily, but she was not able to locate the physician's order.

Interview with Resident #1 on 09/11/24 at 3:30pm revealed:
-He had trouble with chronic constipation and lower intestine symptoms like cramping and pain.
-He did not know all his medications by name because sometimes the medications changed.
-He had not been routinely receiving PEG 3350.
-He had an "as needed" medication for constipation that he asked for to help with his constipation.

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C 330	Continued From page 6 Interview with the facility's Manager on 09/11/24 at 4:45pm revealed: -She must have overlooked Resident #1's order for daily PEG 3350 was not included on the July 2024, August 2024, and September 2024 MARs. -If the MAR did not list PEG 3350 but the resident had PEG 3350 on hand for administration, the MA/SIC should have added PEG 3350 to the MAR and administered the medication as ordered. Attempted telephone with the Administrator on 09/11/24 at 5:00pm was unsuccessful. Refer to the interview with the medication aide/Supervisor in Charge (MA/SIC) on 09/11/24 at 11:30am. Refer to the interview with the facility's Manager on 09/11/24 at 4:45pm. c. Review of Resident #1's physician's order from a gastro-intestinal (GI) clinic follow-up for Crohn's disease dated 04/05/24 revealed an order to "start psyllium SF (sugar free) oral powder (being sent by mail)". (Psyllium oral powder is a fecal stool normalizer used to treat constipation and/or diarrhea.) Review of Resident #1's medication list summary from the primary care provider (PCP) dated 06/13/24 revealed an order for psyllium SF oral powder mix 1 tablespoonful every day for constipation; mix in juice or water and drink. Telephone interview with Resident #1's PCP on 09/11/24 at 2:30pm revealed: -Resident #1 visited the VA clinical services for his medical care.	C 330		

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C 330	Continued From page 7 -Resident #1 had trouble with chronic constipation and lower gastro-intestinal irritation. -Resident #1 would benefit from regularly scheduled treatment of constipation. -Resident #1 should be administered psyllium oral powder routinely unless the resident complained of diarrhea. -The VA clinic maintained a list of medications ordered that included a coordination of orders between the various clinics seen for VA services and was reviewed and updated with each provider's visit. -The medications listed on the visit summary medication list should be considered a comprehensive list of current medications. -The facility should be administering medications as ordered on the medications listed on the office visit summaries. -Psyllium oral powder was listed as a current medication and should be administered as ordered. Observation of Resident #1's medications on hand for administration on 09/11/24 revealed: -There was a was an unopened container of psyllium oral powder dispensed for 300 grams on 03/05/24. -There was an unopened container of psyllium oral powder dispensed for 300 grams on 09/04/24. Review of Resident #1's June 2024 MAR revealed: -There was a handwritten entry for psyllium SF oral powder mix 1 tablespoonful every day for constipation; mix in juice or water and drink. -There was no scheduled time for administration and no documented administration of psyllium oral powder for June 2024.	C 330		

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C 330	Continued From page 8 Review of Resident #1's July 2024, August 2024, and September 2024 from 09/01/24 to 09/11/24 MARs revealed: -There was a handwritten entry for psyllium SF oral powder mix 1 tablespoonful every day for constipation; mix in juice or water and drink. -There was no scheduled time for administration and no documented administration of psyllium oral powder for July 2024, August 2024, and September 2024 from 09/01/24 to 09/11/24. Interview with the MA/SIC on 09/11/24 at 11:30am revealed: -Resident #1 had an adequate supply of psyllium oral powder on hand for administration. -Resident #1's order for psyllium oral powder daily was on listed on the June 2024 MAR, but there was no documentation Resident #1 received PEG. -She remembered psyllium oral powder came by mail for Resident #1 but did not know why she never administered psyllium oral powder. -She did not know why she did not include the entry for psyllium oral powder daily on the July 2024, August 2024, and September 2004 MARs. Interview with Resident #1 on 09/11/24 at 3:30pm revealed: -He had trouble with chronic constipation and lower intestine symptoms like cramping and pain. -He did not know all his medications by name because sometimes the medications changed. -He had not been routinely receiving psyllium oral powder. -He had an "as needed" medication for constipation that he asked for to help with his constipation. Interview with the facility's Manager on 09/11/24 at 4:45pm revealed:	C 330		

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C 330	Continued From page 9 -She must have overlooked Resident #1's order for psyllium oral powder daily was not included on the July 2024, August 2024, and September 2024 MARs. -If the MAR did not list psyllium oral powder but the resident had psyllium oral powder on hand for administration, the MA/SIC should have added psyllium oral powder to the MAR and administered the medication as ordered. Attempted telephone with Administrator on 09/11/24 at 5:00pm was unsuccessful. Refer to the interview with the medication aide/Supervisor in Charge (MA/SIC) on 09/11/24 at 11:30am. Refer to the interview with the facility's Manager on 09/11/24 at 4:45pm. _____ Interview with the medication aide/Supervisor in Charge (MA/SIC) on 09/11/24 at 11:30am revealed: -She was responsible for preparing the residents MARs. -The monthly MARs were handwritten using the residents' medication orders and the previous months MARs. -She made changes to the MARs based on medication orders received for the residents. -Resident #1 received primary care and his medications from the local Veteran's Administration (VA) Hospital clinic. -She reviewed the current medications listed on Resident #1's after visit medication list when he returned from a clinic visit. Interview with the facility's Manager on 09/11/24 at 4:45pm revealed: -She used to be the Administrator but was not the	C 330		

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C 330	Continued From page 10 current Administrator. -The MA/SIC was responsible to hand write MARs from month to month based on the current MAR and any new orders. -The Manager was responsible to review the MARs at the beginning of the month to check behind the MA/SIC. -The Manager reviewed the old MAR and current medication orders at the beginning of each month when she audited the current MAR for medications to be administered.	C 330		