

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PCL832883	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER B J'S FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 714 HADD STREET DURHAM, NC 27704			
(X4) ID PREFIX TAG	BURDEN STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETE DATE	
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 11, 2024.	C 000	The home administrator or manager will ensure new orders, and or changed order are update on the MAR's as prescribed. BBright 11/20/24		
C 330	10A NCAC 130 .1004(a) Medication Administration 10A NCAC 130 .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 (R1) related to a medication for headaches, and 2 medications for constipation. The findings are: Review of Resident R1's current FL2 dated 08/04/23 revealed diagnoses included schizophrenia, atrial fibrillation, and Crohn's disease. a. Review of Resident R1's current FL2 dated 08/04/23 revealed an order for verapamil (used to reduce frequency and duration of headaches) along take one-half tablet 3 times a day. Review of Resident R1's physician's orders dated 08/29/24 revealed an order to discontinue verapamil along one-half tablet 3 times a day.	C 330	The home SIC will notify the manager or administrator when there is a change of order. BBright 11/20/24 The home administrator or manager will ensure at the beginning of the month all MAR's are reviewed & accurate; checking behind the SIC. BBright 11/20/24		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER IDENTIFICATION SIGNATURE

Bartara Bright, Administrator/Manager 11/20/2024

STATE FORM

If continuation sheet 1 of 11

Reviewed and acknowledged
12/12/24 hrp

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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 -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 09/09/24 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	C 330		

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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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C 330	Continued From page 5 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.	C 330			

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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			