

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL092102	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER ELSIE'S PLACE		STREET ADDRESS, CITY, STATE, ZIP CODE 10916 RAVEN ROCK DRIVE RALEIGH, NC 27614		
(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 April 26, 2024.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure tuberculosis testing was completed and documented in the residents' records for 2 of 3 sampled residents (#1, #2). The findings are: 1. Review of Resident #1's FL2 dated 02/07/24 revealed diagnoses included bipolar disorder, tardive dyskinesia, and Parkinson's disease. Review of Resident #1's record revealed there was no documentation of two-step tuberculosis (TB) testing. Interview with Resident #1's case manager on 04/46/24 at 1:30pm revealed:	C 140		

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

TITLE

(X6) DATE

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C 140	Continued From page 1 -She visited Resident #1 two or three times each week and also accompanied her to medical appointments. -Resident #1 was admitted to the facility in October 2023. -Resident #1 lived at another facility prior to moving into this facility, so she thought Resident #1 may have had TB tests at that facility. -She was unsure if Resident #1 had any TB tests at this facility. Refer to telephone interview with the Administrator on 04/26/24 at 1:37pm. 2. Review of Resident #2's FL2 dated 10/12/23 revealed diagnoses included dehydration, urinary tract infection, and early dementia. Review of Resident #2's record revealed there was no documentation of two-step tuberculosis (TB) testing. Interview with Resident #2's family member on 04/26/24 at 12:05pm revealed: -Resident #2 was admitted to the facility in October 2023. -He was unsure if Resident #2 had any TB tests. -Resident #2 lived in an independent living apartment prior to moving to this facility and TB testing was not required at that facility. Refer to telephone interview with the Administrator on 04/26/24 at 1:37pm. Telephone interview with the Administrator on 04/26/24 at 1:37pm revealed: -Either she or the registered nurse (RN) were responsible for ensuring the residents' tuberculosis (TB) tests were completed. -She contacted the facility where Resident #1	C 140		

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C 140	Continued From page 2 previously resided today, 04/26/24, to attempt to obtain a record of Resident #1's TB tests but had not received the records yet. -She did not have any records of TB testing for Resident #2. -She was aware that two-step TB testing was required for all residents. -Resident #1 and Resident #2 should have had two-step TB testing completed and documented in their records.	C 140		
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm , or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the Resident Register was completed within the required time frame for 2 of 3 sampled residents (#1, #2). The findings are:	C 212		

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C 212	Continued From page 3 1. Review of Resident #1's FL2 dated 02/07/24 revealed diagnoses included bipolar disorder, tardive dyskinesia, and Parkinson's disease. Review of Resident #1's Resident Register revealed: -Resident #1's name was entered on line one of the Resident Register. -Sections A-F were not completed by Resident #1's responsible party. - Resident #1's Resident Register was signed by facility staff. Interview with Resident #1's case manager on 04/26/24 at 1:30pm revealed: -She visited Resident #1 two or three times each week. -Resident #1 was admitted to the facility in October 2023, and she was unsure of the exact date. -She completed Resident #1's Resident Register today, 04/26/24. Refer to telephone interview with the Administrator on 04/26/24 at 11:23am. 2. Review of Resident #2's FL2 dated 10/12/23 revealed diagnoses included dehydration, urinary tract infection, and early dementia. Review of Resident #2's Resident Register revealed: -Resident #2's name was entered on line of the Resident Register. -Sections A-F were not completed by Resident #2's responsible party. -Resident #2's Resident Register was signed by facility staff. Interview with Resident #2's family member on	C 212		

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C 212	Continued From page 4 04/26/24 at 12:05pm revealed: -He was unsure of Resident #2's admission date, but it was in October 2023. -He did not complete Resident #2's Resident Register at admission. -He came to the facility to complete Resident #2's Resident Register today, 04/26/24. Refer to telephone interview with the Administrator on 04/26/24 at 11:23am. Telephone interview with the Administrator on 04/26/24 at 11:23am revealed: -Resident #1 and Resident #2 were admitted to the facility in October 2023. -Either she or the registered nurse (RN) were responsible for ensuring the Resident Register was completed for new admissions. -She gave each residents' family member a copy of the Resident Register to complete at the time of admission. -She was unsure why Resident #1 and Resident #2 did not have a completed Resident Register in their records. -She usually checked to make sure the Resident Register was completed at admission. -She must have not checked the records for Resident #1 and Resident #2 to be sure the Resident Register was completed.	C 212		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;	C 342		

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C 342	Continued From page 5 (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure accuracy of the medication administration record for 1 of 3 sampled residents (#1) related to a medication used to treat psychiatric conditions. The findings are: Review of Resident #1's FL2 dated 02/07/24 revealed: -Diagnoses included bipolar disorder, tardive dyskinesia, and Parkinson's disease. -There was an order for Depakote DR 1250mg nightly (Depakote DR is a delayed-release medication used to treat psychiatric conditions). Review of Resident #1's record revealed there was no February 2024 medication administration record (MAR). Review of Resident #1's March 2024 MAR revealed:	C 342		

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C 342	Continued From page 6 -There was an entry for Depakote DR 250mg, take 5 tablets daily at bedtime scheduled for 8:00pm. -Depakote DR 250mg, 5 tablets was documented as administered at 8:00pm on 26 of 30 days. -Depakote DR 250mg, 5 tablets was documented as not administered/refused at 8:00pm on 4 of 30 days. -There was no documentation for Depakote DR 250mg, 5 tablets on 03/31/24. Review of Resident #1's April 2024 MAR revealed: -There was a handwritten entry for Depakote DR 125mg take 5 tablets once daily scheduled for 8:00pm. -Depakote DR 125mg, 5 tablets was documented as administered at 8:00pm on 21 of 25 days. -Depakote DR 125mg, 5 tablets was documented as not administered/refused at 8:00pm on 4 of 25 days. Observation of Resident #1's medications on hand revealed: -Resident #1's medications included a unit dose card of Depakote 250mg DR with 5 tablets in each unit dose bubble. -There were 17 doses of Depakote 250mg DR remaining on the unit dose card. -150 tablets of Depakote 250mg DR were dispensed from the facility's contracted pharmacy on 04/08/24. Interview with a medication aide (MA) on 04/26/24 at 1:18pm revealed: -MAs were responsible for checking the MARs each month to ensure that medication orders were correct. -She followed the MAR and checked the label on the medication when administering medications.	C 342		

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C 342	Continued From page 7 -She had not noticed that Resident #1's medication on hand did not match what was on the MAR. Telephone interview with the Administrator on 04/26/24 at 1:37pm: -MAs were responsible for checking the MARs each month for accuracy. -The pharmacy did not print the April 2024 MAR for Resident #1, so a MAR was handwritten by one of the MAs. -The transcription error must have occurred when handwriting Resident #1's MAR. -MAs should check the MAR and compare the medication label when administering medications.	C 342		
C 415	10A NCAC 13G .1201 (a) Resident Records 10A NCAC 13G .1201 Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Facility Services and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and	C 415		

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C 415	Continued From page 8 (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that medication administration records were maintained in the facility and readily accessible for 3 of 3 sampled residents (#1, #2, #3). The findings are: 1. Review of Resident #1's FL2 dated 02/07/24 revealed diagnoses included bipolar disorder, tardive dyskinesia, and Parkinson's disease. Review of Resident #1's record revealed there was no February 2024 medication administration record.	C 415		

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C 415	Continued From page 9 Refer to interview with a medication aide (MA) on 04/26/24 at 1:13pm. Refer to telephone interview with the Administrator on 04/26/24 at 1:37pm. 2. Review of Resident #2's FL2 dated 10/12/23 revealed diagnoses included dehydration, urinary tract infection, and early dementia. Review of Resident #2's record revealed there was no February 2024 medication administration record. Refer to interview with a medication aide (MA) on 04/26/24 at 1:13pm. Refer to telephone interview with the Administrator on 04/26/24 at 1:37pm. 3. Review of Resident #3's FL2 dated 04/01/24 revealed diagnoses included Parkinson's disease, hypothyroidism, chronic anxiety, chronic depression, and chronic low back pain. Review of Resident #3's record revealed there was no February 2024 medication administration record. Refer to interview with a medication aide (MA) on 04/26/24 at 1:13pm. Refer to telephone interview with the Administrator on 04/26/24 at 1:37pm. Interview with a medication aide (MA) on 04/26/24 at 1:13pm revealed: -The medication administration records (MARs) for previous months were stored in a notebook. -She did not know when the last time was she	C 415		

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C 415	Continued From page 10 saw February 2024 MARs for Resident #1, Resident #2, and Resident #3. -She looked in the notebook and in a storage tote and was unable to locate February 2024 MARs for Resident #1, Resident #2, and Resident #3. Interview with the Administrator on 04/26/24 at 1:37pm revealed: -The MARs for previous months were stored in a notebook. -MAs placed the previous month's MARs in the notebook when a new month started. -She was unsure where February 2024 MARs were located for Resident #1, Resident #2, and Resident #3. -The facility made copies of each residents' MARs when the primary care provider (PCP) came to the facility, so the MARs could have been misplaced at that time. -She was aware the MARs for each resident should be maintained in the facility and be readily accessible.	C 415		