STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032178	A. BUILDING: _____ B. WING _____	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR PROMISE CARE HOMES	4811 BAY POINT DR DURHAM, NC 27713

(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 and the Durham County Department of Social Services conducted an annual survey on 11/13/24.	C 000		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 3 sampled residents (#3) was tested for tuberculosis (TB) upon admission. The findings are: Review of Resident #3's current FL-2 dated 08/19/24 revealed diagnoses included chronic atrial fib, acute hypoxic repertory failure, heart failure, osteoarthritis in the right shoulder, and lymphedema in both lower extremities. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 12/14/23. Review of Resident #3's record revealed:	C 202		

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C 202	Continued From page 1 -There was an immunization record for Resident #3. -There was documentation of tuberculosis (TB) skin test dated 12/21/22 and 12/30/22 but there were no results listed. Interview with Resident # on 11/13/24 at 12:55pm revealed: -She had lived at the facility for about a year. -She did not recall having a TB skin test done since before she had been admitted to the facility. Interview with the Assistant Administrator on 11/13/24 at 12:30pm revealed: -She was responsible for the residents' records. -She was responsible for ensuring the residents' TB skin test were completed and included in their records. -She did record audits once a month. -She knew Resident #3 needed a second TB skin test. -She thought Resident #3 had a TB skin test result because she was admitted from another facility. -She intended to arrange for Resident #3 to have the TB tests done but it had slipped her mind. Interview with the Administrator on 11/13/24 at 4:15pm revealed: -He thought Resident #3 had a complete TB skin test including the results because she was admitted from another facility. -He had not noticed there were no results documented on the immunization record. -He thought the dated documented the first and second tests. -He was aware residents were required to have a TB skin test prior to admission and he was responsible for making sure the TB skin test were completed.	C 202		

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C 202	Continued From page 2 -He would schedule a TB skin test for Resident #3 at the end of the week.	C 202		
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 reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to a fluid reduction medication, a blood thinner, a pain medication, and an inhaler. The findings are: 1. Review of Resident #3's current FL-2 dated 08/19/24 revealed a diagnoses of pulmonary hypertension, essential hypertension, chronic atrial fibrillation, heart failure, stage 3 chronic kidney disease, lymphedema of both lower extremities, history of deep vein thrombosis (DVT) of lower extremity, history of pulmonary embolism, chronic anticoagulation, reactive airway disease, osteoarthritis involving multiple joints, chronic right shoulder pain and acute hypoxic respiratory failure.	C 330		

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C 330	Continued From page 3 Review of Resident #3's hospital after visit report revealed she had a hospital stay from 08/13/24 to 08/19/24. a. Review of Resident #3's current FL-2 dated 08/19/24 revealed an order for torsemide (used to treat fluid retention) 20mg once daily. Review of Resident #3's physician's orders dated 08/21/24 revealed an order to increase Resident #3's torsemide 20mg from once daily to twice daily. Review of Resident #3's after visit report signed by the primary care provider (PCP) on 11/08/24 revealed there was an order to discontinue Resident #3's torsemide 20mg twice daily and to begin torsemide 20mg once daily every other day. Observation of Resident #3's medications on hand on 11/13/24 at 10:40am revealed: -There was a card of 30 torsemide 20mg tablets labeled 1 of 2 dispensed on 09/16/24; there were six tablets available for administration. -There was a card of 30 torsemide 20mg tablets labeled 2 of 2 dispensed on 09/16/24; there were 30 tablets available for administration. -There was a card of 30 torsemide 20mg tablets labeled 1 of 2 dispensed on 10/16/24; there were 30 tablets available for administration. -There was a card of 30 torsemide 20mg tablets labeled 2 o 2 dispensed on 10/16/24; there were 21 tablets available for administration. -There was a card of 15 torsemide 20mg tablets labeled 1 of 1 dispensed on 11/12/24; there were 15 tablets available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/13/24 at 1:25pm revealed:	C 330		

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C 330	Continued From page 4 -Resident #3's had an order dated 08/19/24 for torsemide 20mg once daily it was increased to twice daily on 08/21/24 and then discontinued on 11/08/24. -Resident #3's current order dated 11/08/24 was for torsemide 20mg every other day. -Resident #3's torsemide was on a cycle fill. -Sixty tablets of torsemide 20mg were dispensed on 08/14/24, 09/12/24, and 10/14/24; 60 tablets were for a thirty-day supply. -Fifteen tablets of torsemide 20mg were dispensed on 11/12/24. -Torsemide was typically ordered to reduce fluid and a potential outcome could include swelling in the extremities, hypertension, breathing issues or increased blood pressure if not administered as ordered. Telephone interview with Resident #3's PCP on 11/13/24 at 3:28pm revealed: -Resident #3 was ordered torsemide by her pulmonologist. -Torsemide was ordered to remove fluid from a resident's chest and extremities. -Possible outcomes of not administering torsemide as ordered could include increased edema or high blood pressure. -Resident #3 had never complained about edema but she did have hypertension. -Resident #3 was last seen in her office on 10/29/24 and her blood pressure was 127 systolic and 52 diastolic. -She expected Resident #3's medications to be administered on time and as they had been ordered. Interview with a medication aide (MA) on 11/13/24 at 2:45pm revealed: -Resident #3 had an order for torsemide twice a day.	C 330		

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OUR PROMISE CARE HOMES	4811 BAY POINT DR DURHAM, NC 27713

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C 330	Continued From page 5	C 330		

-She was good about taking her medications and did not refuse.
-Sometimes she administered the evening medications.

Interview with a second MA on 11/13/24 at 3:00pm revealed:
-Resident #3 had an order for torsemide twice a day.
-Resident #3 used to get her torsemide in the evenings and the mornings but now she got it at noon.
-The torsemide made her "pee" a lot so she knew she got it.
-She had not noticed it had changed from twice daily to once every other day.
-She followed the eMAR; she was still administering the torsemide from the older cards.
-There was nothing noted on the medication card to alert her of a medication change.
-There should have been a sticker with an alert to the order change on the card.
-She did not know why there were no initials on the days she administered Resident #3 her torsemide.

Attempted telephone interview with Resident #3's Pulmonologist on 11/13/24 at 1:48pm was unsuccessful.

Refer to the interview with a MA on 11/13/24 a 2:45pm.

Refer to the interview with a second MA on 11/13/24 at 3:00pm.

Refer to the interview with the Assistant Administrator on 11/13/24 at 3:45pm.

Refer to the interview with the Administrator on

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C 330	Continued From page 6 11/13/24 at 4:15pm. Based on observation, interviews, and record reviews it was determined Resident #3 was not interviewable. b. Review of Resident #3's current FL-2 dated 08/19/24 revealed an order for apixaban (used to thin the blood) 5mg every twelve hours. Observation of Resident #3's medications on hand on 11/13/24 10:40am revealed: -There was a card of apixaban 5mg tablets labeled 2 of 2 dispensed on 09/16/24; there were 8 tablets available for administration. -There was a card of 30 apixaban 5mg tablets labeled 1 of 2 dispensed on 10/16/24; there were 13 tablets available for administration. -There was a card of 30 apixaban 5mg tablets labeled 2 of 2 dispensed on 10/16/24; there were 30 of 30 tablets available for administration. -There was a card of 30 apixaban 5mg tablets labeled 1 of 2 with a dispense date of 11/15/24; there were 30 of 30 tablets available for administration. -There was a card of 30 apixaban 5mg tablets labeled 2 of 2 with a dispense date of 11/15/24; there were 30 of 30 tablets available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/13/24 at 1:25pm revealed: -Resident #3 had a current order for apixaban 5mg every 12 hours. -Resident #3's apixaban was on a cycle fill. -Sixty tablets of apixaban 5mg were dispensed on 08/14/24, 09/12/24, 10/14/24, and 11/12/24; sixty	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 7	C 330		

tablets were a 30-day supply.
-Apixaban was a blood thinner and a potential outcome could be blood clots if it was not administered as ordered.

Telephone interview with Resident #3's PCP on 11/13/24 at 3:28pm revealed:
-Resident #3 was ordered apixaban by her cardiologist.
-Apixaban was a blood thinner and ordered because Resident #3 had a history of DVT; apixaban would keep a DVT from happening again.
-If Resident #3 was not administered her apixaban as ordered a possible outcome could be a DVT, a pulmonary embolism (PE) or a stroke.
-She expected Resident #3's medications to be administered on time and as they had been ordered.

Interview with a MA on 11/13/24 at 2:45pm revealed:
-Resident #3 only had an order for apixaban once a day.
-Sometimes she administered the evening medications to the residents.

Interview with a second MA on 11/13/24 at 3:00pm revealed:
-She only administered Resident #3's apixaban once a day because she was not at the facility in the evening when it was scheduled.
-She administered the apixaban in the morning and documented the administration.
-She did not know why Resident #3 had extra cards of apixaban.

Attempted telephone interview with Resident #3's Cardiologist on 11/13/24 at 2:00pm was unsuccessful.

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	FCL032178	A. BUILDING: _____ B. WING _____	11/13/2024

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OUR PROMISE CARE HOMES	4811 BAY POINT DR DURHAM, NC 27713

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C 330	Continued From page 8 Refer to the interview with a MA on 11/13/24 a 2:45pm. Refer to the interview with a second MA on 11/13/24 at 3:00pm. Refer to the interview with the Assistant Administrator on 11/13/24 at 3:45pm. Refer to the interview with the Administrator on 11/13/24 at 4:15pm. Based on observation, interviews, and record reviews it was determined Resident #3 was not interviewable. c. Review of Resident #3's current FL-2 dated 08/19/24 revealed an order for gabapentin (used to relieve pain) 100mg twice daily. Observation of Resident #3's medications on hand on 11/13/24 at 10:40am revealed: -There was a card of 30 gabapentin 100mg tablets labeled 1 of 2 with a dispense date of 09/16/24; there were 30 of 30 tablets available for administration. -There was a card of 30 gabapentin 100mg tablets labeled 1 of 2 with a dispense date of 10/16/24; there were 30 of 30 tablets available for administration. -There was a card of 30 gabapentin 100mg tablets labeled 2 of 2 with a dispense date of 10/16/24; there were 20 of 30 tablets available for administration. -There was a card of 30 gabapentin 100mg tablets labeled 1 of 2 with a dispense date of 11/15/24; there were 30 of 30 tablets available for administration. -There was a card of 30 gabapentin 100mg	C 330		

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	FCL032178	A. BUILDING: _____ B. WING _____	11/13/2024

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OUR PROMISE CARE HOMES	4811 BAY POINT DR DURHAM, NC 27713

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C 330	Continued From page 9	C 330		

tablets labeled 2 of 2 with a dispense date of 11/15/24; there were 30 of 30 tablets available for administration.

Telephone interview with Resident #3's PCP on 11/13/24 at 3:28pm revealed:
-Resident #3 had a history of pain related to arthritis in her knees and shoulders.
-She was ordered gabapentin for pain relief.
-She could potentially experience increased pain in those areas if she was not administered her medications as ordered.
-She expected Resident #3's medication to be administered on time, as ordered and for the resident to take them.

Interview with a medication aide (MA) on 11/13/24 at 2:45pm revealed:
-Resident #3 had an order for gabapentin twice a day.
-Sometimes she would administer the gabapentin to Resident #3 before she left for the day.
-Resident #3 did not complain of pain.

Interview with a second MA on 11/13/24 at 3:00pm revealed:
-Resident #3 was administered her gabapentin twice daily for her "nerves".
-She did not complain of pain to her.

Refer to the interview with a MA on 11/13/24 a 2:45pm.

Refer to the interview with a second MA on 11/13/24 at 3:00pm.

Refer to the interview with the Assistant Administrator on 11/13/24 at 3:45pm.

Refer to the interview with the Administrator on

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	FCL032178	A. BUILDING: _____ B. WING _____	11/13/2024

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C 330	Continued From page 10 11/13/24 at 4:15pm. Based on observation, interviews, and record reviews it was determined Resident #3 was not interviewable. d. Review of Resident #3's current FL-2 dated 08/19/24 revealed an order for tiotropium bromide inhaler (used to prevent bronchospasm) 18mcg inhale one capsule once daily. Observation of Resident #3's medications on hand on 11/13/24 10:40am revealed there was a box of 30 capsules of tiotropium bromide 18mcg for use in a hand-held inhaler dispensed on 09/04/24; there were 11 capsules available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/13/24 at 1:25pm revealed: -Resident #3 had a current order for tiotropium bromide 18mcg inhale one capsule once daily via a hand-held inhaler. -Resident #3's tiotropium bromide was not on a cycle fill and needed to be requested by the facility when it needed to be refilled. -Thirty capsules of tiotropium bromide were dispensed on 05/29/24, 07/16/24, and 09/04/24; a thirty-day supply was dispensed each time. -Tiotropium bromide was used to treat breathing issues and a potential outcome could be worsening of breathing and decreased oxygen levels if not administered as ordered. Telephone interview with Resident #3's PCP on 11/13/24 at 3:28pm revealed: -Resident #3 was ordered tiotropium bromide because she had chronic obstructive pulmonary disease (COPD) and was on oxygen.	C 330		

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OUR PROMISE CARE HOMES	4811 BAY POINT DR DURHAM, NC 27713

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C 330	Continued From page 11 -Resident #3 had multiple comorbidities so it would be difficult to determine if a recent hospital stay due to low oxygen saturation would indicate missed doses of her tiotropium bromide. -If Resident #3 was not administered her tiotropium bromide as ordered she possibly could experience shortness of breath and wheezing. -Resident #3's base line oxygen levels were low. -She expected Resident #3's medications to be administered on time, for the resident to take them and for the order to be followed. Interview with a MA on 11/13/24 at 2:45pm revealed: -Resident #3 had an inhaler she used once in the mornings. -She would "pop" the pill into the inhaler and hand it to the resident to inhale. -Resident #3 had low oxygen levels in August and was sent to the hospital; she was also on continuous oxygen. -Resident #3 had not complained of shortness of breath since returning from the hospital. Interview with a second MA on 11/13/24 at 3:00pm revealed: -Resident #3 had an inhaler once in the morning. -Resident #3 would not let anyone forget about the inhaler; she would remind the staff she needed it. -She would drop the capsule into the inhaler and give it to Resident #3 to breath it in herself. -One box of capsules lasted about thirty days and the pharmacy automatically sent refills. Refer to the interview with a MA on 11/13/24 a 2:45pm. Refer to the interview with a second MA on 11/13/24 at 3:00pm.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 12 Refer to the interview with the Assistant Administrator on 11/13/24 at 3:45pm. Refer to the interview with the Administrator on 11/13/24 at 4:15pm. Based on observation, interviews, and record reviews it was determined Resident #3 was not interviewable. _____ Interview with a MA on 11/13/24 a 2:45pm revealed: -She was responsible for checking in the medication from the pharmacy. -She wrote the dates the medication was started on the top of the medication card. -She removed the old [previous] medication cards and replaced them with the new medication cards on the 15th of every month. -She sent the old medication cards back to the pharmacy. -She had began this process in July 2024. -Resident #3 had a lot of medication because they used up the medication she came in with when she was admitted in December 2023. -The MAs were supposed to always use the most recent medication card. -She thought maybe the new MAs were not looking at the dates on the card. -There should not have been all the excess medication because the staff was not sending the unused medication back to the pharmacy. -She did cart audits about once a week. -When she did a cart audit she checked to see if the medication was available. -She reordered medication when it was not available or not on the cart. -She removed discontinued medication from the cart.	C 330		

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	FCL032178	A. BUILDING: _____ B. WING _____	11/13/2024

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C 330	Continued From page 13 -She compared the medication order on the medication card to the order in the eMAR before administering the medication. Interview with a second MA on 11/13/24 at 3:00pm revealed: -Sometimes she administered Resident #3 her evening medications before she left for the day. -Sometimes the Resident #3 would refuse her medication because she would become confused and thought she had already taken it. -She would give Resident #3 a few minutes and come back and administer her medication. -She would check off on medication when She came to work to make sure there was enough to administer. -If there was a medication that was missing, she would let the Assistant Administrator know so it could be ordered. -She checked once a week to see who needed medications. -There was a "overstock" supply of medication they were supposed to pull from when a resident needed medication. -The MAs were responsible for ordering any medications the pharmacy did not send. -They administered the medication that was already on the cart until they were all gone and then moved on to the "overstock" supply. -The dates they started new medication cards varied. -She always compared the medication to the eMAR three times before administering any medication and documented immediately after the administration. -She did not know why resident #3 had so many extra medications. Interview with the Assistant Administrator on 11/13/24 at 3:45pm revealed:	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032178	A. BUILDING: _____ B. WING _____	11/13/2024

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C 330	Continued From page 14 -The MA's conducted cart audits. -They compared the meds to the eMAR, looked for discontinued medications and removed them from the cart, and ordered new medication from the pharmacy when medication was at two weeks of running out. -She checked the eMAR to see if meds were being administered; she knew medications were being administered correctly because she saw where the MAs documented on the eMAR. -Resident #3 came to the facility with medications when she was admitted and 2023. -She did not have an inventory of the medications Resident #3 was admitted with and she had medications from the hospital. -The pharmacy automatically sent medication on a cycle fill. -The facility could call and request a hold on medication, but it was very difficult to get in touch with the pharmacy, so they just let the pharmacy cycle fill all medications. -Resident #3 would always have the extra medications. Interview with the Administrator on 11/13/24 at 4:15pm revealed: -The MAs were supposed to compare the medication card to the eMAR three times, remove the medication from the card, administer the medication, watch the resident and then document on the eMAR. -The MAs and the Assistant Administrator conducted [medication] cart audits; the MAs' audits were weekly, and the Assistant Administrator's audit was monthly. -Resident #3 had extra medication because the cycle fill came in today, 11/13/24. -Resident #3 had extended visits to the hospital and had a buildup of medication. -She had two cataract surgeries where	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 330	Continued From page 15 medications were held the day before her surgery and the day of the surgery, and a hospital visit in August 2024 for seven days. -They had tried to stop the pharmacy from cycle filling medications but had been unsuccessful. -He knew the MA's were administering medication could because he could see the documentation on the eMAR. -There should have been an order change sticker on any medications that had order changes on them. -He spoke with the morning staff every day, but he did not speak to the evening staff. -He ensured the staff were administering medications to the residents because he asked them daily if any residents had missed any medication.	C 330		