STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING			R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	: # 2	RTHA WILSO	N ROAD		
		BLANCH	, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{C 000}	Initial Comments		{C 000}			
		ensure Section conducted a on 07/01/21-07/02/21.				
C 133	10A NCAC 13G. 04 Medication Staff	.03(c) Qualifications of	C 133			
	Medication Staff (c) Medication aide supervise the admir except persons aut licensure laws to accomplete six hours	es and staff who directly nistration of medications, horized by state occupational dminister medications, shall of continuing education medication administration.				
	interviews, the facilimedication aides sa	ons, record reviews, and ity failed to ensure 1 of 1 ampled (A) completed six education annually related to				
	The findings are:					
	personnel record re -There was docume a 5-hour medication -There was docume state written medica -There was no docume	entation Staff A had completed in training class on 11/27/18. entation Staff A passed the ation examination on 12/20/18. umentation Staff A completed cation units (CEU) related to				
	revealed:	A on 07/02/21 at 11:37am ix hours of CEU related to tration annually.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7. BOILDING.		R	
		FCL017018	B. WING			2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	サン	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 133	Continued From pa	ge 1	C 133			
	-She did not recall when she last had training on medication administration.					
	Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.					
{C 145}	5} 10A NCAC 13G .0406(a)(5) Other Staff Qualifications		{C 145}			
	10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;					
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR).					
	The findings are:					
	personnel record re -There was no docu Staff A.	umentation of the hire date for umentation indicating a HCPR				
	revealed: -She thought her fa HCPR.	A on 07/02/21 at 11:37am mily member had checked her sults of the HCPR were in her				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 2 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		FCL017018	B. WING		07/02/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	- 丑ソ	THA WILSO NC 27212	N ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
{C 145}	Continued From pa	ige 2	{C 145}			
	personnel record.					
	Documentation of Staff A's HCPR was requested on 07/02/21 but was not provided by survey exit.					
	Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.					
C 171	10A NCAC 13G .05 For Licensed Healt	504(a) Competency Validation h	C 171			
	10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.					
	facility failed to ens A) had completed of licensed health pro- related to checking	et as evidenced by: s and record reviews, the ure 1 of 1 sampled staff (Staff competency validation for fessional support (LHPS) task finger stick blood sugar.				
	The findings are:					
	Review of the Staff (SIC) personnel red	A's, Supervisor-in-Charge cord revealed:				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 3 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			B WING		F	
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S THA WILSO	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	- 丑ソ	NC 27212	NINOAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 171	Continued From pa	ige 3	C 171			
	Staff AThere was no doc	umentation of a hire date for umentation of Staff A's LHPS validation checklist.				
	were orders to che	sident's records revealed there ck FSBS twice daily for one nother resident and weekly for				
	Interview with Staff A on 07/02/21 at 11:37am revealed: -Her family member who was a nurse had reviewed the task of FSBS with herThere were no other LHPS tasks for any of the current residentsThe nurse did not complete a LHPS tasks competency validation checklist because she did not have the form with her.					
	at 11:48am reveale -The SIC did not we her glovesThe SIC asked for glucometer onThe SIC performe -The SIC attempted glucometer strip be machine, after reali strip in the glucome place blood on the absorb blood from	ash her hands before applying directions on how to turn the d a finger stick on Resident #1. It to add blood to the fore placing the strip in fizing she needed to place the eter she then attempted to strip instead of allowing strip to the end of strip, sident #1's glucometer to check S.				
		ne interview with the facility's urse 07/01/21 at 12:02pm was				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 4 of 69

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R		
		FCL017018	B. WING			2/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
TAYLOR	FAMILY CARE HOME	・ 世フ	THA WILSO NC 27212	N ROAD			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N N	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
C 171	Continued From pa	ge 4	C 171				
	Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.						
{C 230}	10A NCAC 13G .0801(a) Resident Assessment		{C 230}				
	(a) A family care he assessment of eac	801 Resident Assessment ome shall assure that an initial h resident is completed within ion using the Resident					
	This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that an initial assessment was completed within 72 hours of admission using the Resident Register for 1 of 1 sampled residents (#2).						
	The findings are:						
	08/05/20 revealed	lar disorder, adjustment					
		t #2's record revealed there egister available for review.					
		Supervisor-in-Charge (SIC) on revealed Resident #2 was lity on 05/11/21.					
	revealed she had b	dent #2 on 07/01/21 at 9:36am een at the facility for "over a s not sure of her date of					

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 5 of 69

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. Bollbirto.		R	
		FCL017018	B. WING			2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO	N ROAD		
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	NC 27212	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 230}	0} Continued From page 5		{C 230}			
	07/02/21 at 9:05am -She had not comp Resident #2 becaus resident's guardian -She was responsit Register on new ad -She admitted the r	leted a resident register on se she did not know who the was. ble for completing the Resident				
{C 231}	10A NCAC 13G .08	01(b) Resident Assessment	{C 231}			
	(b) The facility shall each resident is confollowing admission thereafter using an established by the Decontaining at least trequired on the established on the established by the Decontaining at least trequired on the established on the established by the Decontaining at least trequired on the established on the est	in activities of daily living. ing are bathing, dressing, and eating. The dicate if the resident requires ent's physician or other expressional, a provider of elopmental disabilities or ervices or a community				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			D 14/11/0		F	
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	RTHA WILSO , NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 231}	Continued From pa	ge 6	{C 231}			
	interviews, the facili	et as evidenced by: ons, record reviews, and ity failed to ensure that a care ent were completed within on for 1 of 3 sampled				
	The findings are: Review of Resident #2's current FL-2 dated 08/05/20 revealed diagnoses included schizophrenia, bipolar disorder, adjustment disorder, and altered mental status.					
		upervisor-in-Charge (SIC) on revealed Resident #2 was lity on 05/11/21.				
	Review of Resident was no care plan av	#2's record revealed there vailable for review.				
	Supervisor-in-Charges: 9:05am revealed: -Resident #2 had no provider (PCP)She was responsible care plans on new a	upervisor-in-Charge on ge (SIC) on 07/02/21 at ot been to see a primary care ble for completing the resident admissions. esidents to the facility.				
	Attempted telephon Administrator on 07 unsuccessful.	e interview with the //02/21 at 12:14pm was				
{C 246}	10A NCAC 13G .09	02(b) Health Care	{C 246}			
	10A NCAC 13G .09	02 Health Care				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 7 of 69

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R		
		FCL017018	B. WING		07/0	2/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TAYLOR	TAYLOR FAMILY CARE HOME #2			N ROAD			
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	NC 27212	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 246}	Continued From pa	ge 7	{C 246}				
		ll assure referral and follow-up and acute health care needs					
	reviews, the facility completed for 2 of 3 a resident who had	et as evidenced by: ons, interviews, and record failed to ensure referrals were 3 sampled residents related to a referral for an eye exam resident who had a referral to					
	The findings are:						
	07/07/20 revealed of	ent #1's current FL-2 dated diagnoses included diabetes, tia, anxiety, and hypertension.					
	Review of Resident #1's primary care provider (PCP) visit summary dated 06/01/21 revealed: -The reason for the visit was listed as the resident needed a referral to podiatry to have the resident's nails trimmedA diagnosis of toenail deformity was documentedA referral to a podiatrist was scheduled.						
	11:26am revealed: -She had not been -She wanted to go	to a podiatrist. why she had not been to a					
	at 11:26am reveale	ident #3's toenails on 07/01/21 d: her left foot was completely					

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 8 of 69

	Of Fleath Service IN		1			
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
VIAD LEVIN	OI OOKKLOTION	DENTILIOATION NOINDEN.	A. BUILDING:		COMP	1
					F	₹
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
10 101	THOUBER OR SOLVE LIER		THA WILSO			
TAYLOR FAMILY CARE HOME #2			NC 27212	NINOAD		
	0/11/11/12/07/			DDOWDEDIO DI ANI OF CODDECTION		
(X4) ID PREFIX	-	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
{C 246}	Continued From pa	ae 8	{C 246}			
,	•		,			
		e rest of her toes on the left				
		the end of her toes and were				
	jagged.	her right foot was over ¾				
	missing.	Thei light loot was over 74				
		of her toes on the right foot				
		end of the toe by ¼ inch and				
	one was beginning	•				
	-Both of her feet were covered in a build-up of dead and peeling skin.					
		v with Resident #3's PCP's				
		on 07/01/21 at 2:21pm				
		was made for Resident #3 to				
	see a podiatrist on	00/01/21.				
	Telephone interviev	v with the appointment				
		oodiatrist office on 07/01/21 at				
	2:46pm revealed:					
	-A referral was rece	eived for Resident #1 on				
	06/01/21.					
		d to contact the resident to				
	schedule an appoir					
		le messages at the telephone				
	number provided.					
	the facility's telepho	lephone number provided was				
		ed her telephone call.				
	110 ono nad rotam	od nor tolophono dall.				
	Interview with the S	Supervisor-in-Charge (SIC) on				
	07/02/21 at 11:22ar					
		a voicemail from the podiatry				
	office.					
		the call to the podiatry office.				
		none area code and thought				
	the podiatry office v					
		red up with Resident #1's PCP				
	to request a difference	nt reierral. e the podiatrist's office that had				
		n 20 minutes away from the				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 9 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					F	
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	- サン	THA WILSO NC 27212	N KOAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 246}	Continued From pa	nge 9	{C 246}			
	facility.					
	Attempted telephone interviews with Resident #1's PCP on 07/01/21 at 4:17pm unsuccessful.					
		ne interview with the 7/02/21 at 12:14pm was				
	07/30/20 revealed of schizophrenia, psychizoaffective disc	chosis, tobacco disorder,				
	03/26/21 revealed	t #3's physician's order dated an order to schedule Resident e exam (once per year).				
	10:30am revealed: -She had her eyes -She did not recall	checked last year. the date of her last exam. I her to have her eyes checked				
	07/02/21 at 11:00ar -She had not sched -She did not know seen by an eye dod -She would call the appointmentShe had forgotten appointment that w -She told Resident needed to schedule	duled Resident #3's eye exam. when Resident #3 was last ctor. eye doctor to schedule the to schedule the eye ras ordered on 03/26/21. #3 two weeks ago that she e her eye appointment.				
		w with a nurse at Resident #3's der's (PCP) office on 07/06/21				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	COMPLETED		
		FCL017018	B. WING			⊰ 02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	RTHA WILSOI , NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 246}	at 1:32pm revealed -Resident #3 was s -Resident #3 was e exams because of l Attempted telephon #3's PCP on 07/01/ 9:35am were unsuch Attempted telephon	een on 06/25/21 by the PCP. een on 06/25/21 by the PCP. expected to have annual eye her diagnoses of diabetes. e interviews with Resident 21 at 2:00pm and 07/02/21 at excessful.	{C 246}			
{C 249}	10A NCAC 13G .09 (c) The facility shal following in the residual of the facility shall following in the residual of the facility of the facili	I assure documentation of the	{C 249}			
	Based on observati interviews, the facili implementation of p sampled residents (Resident #3) with o	YPE B VIOLATION dings, the previous Type B pated. ons, record reviews, and ty failed to ensure the physician's orders for 3 of 3 (Resident #1, #2, and rders for finger stick blood ks (Resident #1, #2, #3) and				

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			R	
		FCL017018	B. WING)2/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE			
TAYLOR FAMILY CARE HOME #2			RTHA WILSO , NC 27212	N ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
{C 249}	Continued From pa	nge 11	{C 249}				
	The findings are: 1. Review of Resido 08/05/20 revealed oschizophrenia, bipodisorder, and altered a. Review of Resido 08/05/20 revealed a blood sugar (FSBS Interview with the SO7/01/21 at 9:48 amadmitted to the facing Based on review of Supervisor-in-Charhave a May 2021 morecord (MAR) available of Resident revealed: -There was no entrest of FSBS was checked Resident #2 did not available to be reviewedled: -She had been at the but was not sure of the solution of the solut	ent #2's current FL-2 dated diagnoses included plar disorder, adjustment ed mental status. ent #2's current FL-2 dated an order to check finger stick) twice daily. Supervisor-in-Charge (SIC) on revealed Resident #2 was lity on 05/11/21. Frecord and interview with the ge (SIC) Resident #2 did not nedication administration lable to be reviewed. It #2's MAR for June 2021 It wo check Resident #2's umentation Resident #2's umentation Resident #2's twice daily. It have a May 2021 MAR ewed. It have a May 2021 MAR ewed. It have a May 2021 MAR ewed. It have a May 2021 MAR ewed.					
	-She had not had h had been admitted -She did not know l ordered to be chec	er FSBS checked since she to the facility. how often her FSBS were					

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 12 of 69

Division of Health Service Regulation						
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	 -	COMP	LETED
					F	2
		FCL017018	B. WING			2/2021
		1 0 20 11 0 10	I.		0170	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAVI OR	FAMILY CARE HOME	: #2 1136 BEF	RTHA WILSO	N ROAD		
IAILON	TAIMET GARE HOME	BLANCH	, NC 27212			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	REGULATORT OR E	SCIDENTII TING INI OKWATION)	TAG	DEFICIENCY)	INAIL	D/ ((E
{C 249}	Continued From pa	ge 12	{C 249}			
	but she did not reca	all how often.				
	Interview with the S revealed:	IC on 07/02/21 at 11:02am				
	-She did not know f	Resident #2 was supposed to				
	have twice daily FS					
		e order for twicedaily FSBS on				
	1	; she must have overlooked				
	the orderShe did not send Resident #2's FL-2 to the					
		her fax machine was broken.				
		ot have a glucometer to check				
	her FSBS.	it have a glucometer to check				
		ned a glucometer for Resident				
		I not know the resident had				
	orders for FSBS.					
		v with a pharmacist at the				
		pharmacy on 07/01/21 at				
	1:20pm revealed:					
	-The pharmacy ento the facility.	ered orders on the MARs for				
		was not sent to the				
	pharmacy.					
		er on file for Resident #2's				
	twice daily FSBS.					
	Talamban Soton	Desident #Observer				
		with Resident #2's primary				
) on 07/01/21 at 3:56pm				
	revealed:	Resident #2's FL-2 when she				
		at the previous facility.				
		ed to have her FSBS checked				
	twice daily as order					
		S checks were ordered				
		ncerned Resident #2's				
		as not controlled because				
		history of non-compliance with				
		efused medications.				
		nelp him monitor Resident #2's				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 13 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING		R 07/02/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	RTHA WILSO , NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY)	.D BE	(X5) COMPLETE DATE
{C 249}	diabetesIf Resident #2's FS resident could be exwhich could lead to including liver, lungorgans" could be im-No one had contact #2's orders. Attempted telephone Administrator on 07 unsuccessful. b. Review of Reside 08/05/20 revealed a resident's blood predicted for the month. Based on review of Supervisor-in-Charghave a May 2021 in record (MAR) avail Review of Resident administration record revealed: -There was no entry on the 1st and 15th -There was no document of the month	BBS were not checked, the experiencing hyperglycemia long-term organ damage, is, eyes, "pretty much all appacted. Ited him to discuss Resident interview with the 1/02/21 at 12:14pm was sent #2's current FL-2 dated an order to check the essure (BP) on the 1st and interview with the 1/02/21 record a	{C 249}			

6899

Division of Health Service Regulation STATE FORM

Division of Health Service Regulation			T		T	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		FCL017018	B. WING			2/2021
		1 02017010			1 0770	LI LUL I
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAVLOD		1136 BEF	THA WILSO	N ROAD		
IAILOR	FAMILY CARE HOME	BLANCH	NC 27212			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				BEI IOIEIOI)		
{C 249}	Continued From pa	ge 14	{C 249}			
	Interview with the S	IC on 07/02/21 at 11:02am				
	revealed:	10 011 01/02/21 at 11.02am				
		Resident #2 was supposed to				
		ed twice a month, on the 1st				
	and 15th.					
	-She did not see the	e order for the BP checks on				
	Resident #2's FL-2;	she must have overlooked				
	the order.					
	-She did not send Resident #2's FL-2 to the pharmacy because her fax machine was broken.					
		with a pharmacist at the				
		pharmacy on 07/01/21 at				
	1:20pm revealed:					
		ered orders on the MARs for				
	the facility.)aa mat aamt ta tha				
		was not sent to the				
	pharmacy.	er on file for Resident #2's				
	twice monthly blood					
	twice monthly block	pressure checks.				
	Observation of Res	ident #2's BP on 07/01/21 at				
	10:57am revealed:					
		gital BP machine to check the				
	resident's BP.	•				
	-The BP reading wa	as 74/56.				
	-A second BP was	obtained and the reading was				
	100/60.	-				
		ained and the reading was				
	99/68.					
	Talambaration	white Decident #Ole or to one				
		with Resident #2's primary				
) on 07/01/21 at 3:56pm				
	revealed:	Resident #2's FL-2 when she				
	•	at the previous facility.				
		nedication for high blood				
	pressure.	nedication for high blood				
		Resident #2's blood pressure				
		s ordered because he would				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 15 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7 th BOILDING.		R	
		FCL017018	B. WING			02/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	TAYLOR FAMILY CARE HOME #2 BLANCH			N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{C 249}	not know if the resimal maintained at a the blood pressure was -No one had contact #2's orders. Attempted telephor Administrator on 07 unsuccessful. 2. Review of Reside 07/07/20 revealed: -Diagnoses include anxiety, diabetes, arbere was an orderinger stick blood since where was no entrestick blood since was no entrest. There was no door FSBS was checked 4:34pm revealed and Resident #1's primare 10/16/20 for glucon FSBS daily. Interview with Residence with the since she moved in ago."	dent's blood pressure was rapeutic range or not if the sonot checked. Sted him to discuss Resident the interview with the 17/02/21 at 12:14pm was sent #1's current FL-2 dated and Alzheimer's dementia, and hypertension. For to check Resident #1's sugar (FSBS) once a week. It #1's medication rads (MAR) for April 2021, May 21 revealed: The system of the pharmacy on 07/01/21 at the order was received from any care provider (PCP) on the pharmacy on 07/01/21 at 1 the order was received from any care provider (PCP) on the pharmacy on 07/01/21 at 1 the order was received from any care provider (PCP) on the pharmacy on 07/01/21 at 8:55am of the facility "almost a year supervisor-in-Charge (SIC) on supervisor-in-Charge (SIC) on	{C 249}			
		ked Resident #1's FSBS				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 16 of 69

	Of Fleatill Service IN	guiation			1	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` ,	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		FCL017018	B. WING			2/2021
NAME OF I	DDU/IDED OD SLIDDI IED		DESS CITY O	STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	TAYLOR FAMILY CARE HOME #2			N RUAD		
			NC 27212			ı
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
{C 249}	Continued From pa	ge 16	{C 249}			
	because Resident #	#1's glucometer was not				
	working.					
		S was checked by the SIC's				
		o was a nurse, using a				
		ily member had brought with				
		metime in May 2021. ent #1's FSBS was 102 when				
	•					
	it was checked, but she did not document the reading on Resident #1's MARShe had not attempted to obtain a new					
	glucometer for Res					
	_					
		ident #1's glucometer on				
	07/01/21 at 11:48ar					
		ig was not labeled and the				
	glucometer was not	had not been set in the				
	glucometer.	riad flot been set in the				
	0	S results in the glucometer's				
	history.	e recalle in the gladelineter c				
	•					
	Observation of Res	ident #1's FSBS on 07/01/21				
	at 11:48am reveale					
		ident #1's glucometer to check				
	the resident's FSBS					
	-The FSBS reading	was 140.				
	Attempted telephon	e interviews with Resident				
		21 at 4:17pm unsuccessful.				
	Attempted telephon	e interview with the				
		//02/21 at 12:14pm was				
	unsuccessful.					
	-	ent #3's current FL2 dated				
	07/30/20 revealed o					
	schizophrenia, psyc	chosis, tobacco disorder,				
		etes type 2, hyperlipidemia.				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		-0.0.	B. WING		F	
		FCL017018			07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S THA WILSO	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・サン	NC 27212	N KOAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{C 249}	Continued From pa	ge 17	{C 249}			
	Review of Resident 09/18/20 revealed: -There was an order finger stick blood standailyThere was an order FSBS checked ever Review of Resident 03/26/21 revealed to fasting FSBS every medication administration administration and Junature was no entry dailyThere was an entry four times a day.	at #3's physician's order dated are to discontinue the resident's ugar (FSBS) checks four times are for the resident to have ry morning. at #3's physician's order dated there was an order to check amorning and record on the stration record (MAR). at #3's MARs for April 2021, the 2021 revealed: and the provided the resident's FSBS are to check the resident's FSBS are to discontinuous that the resident's provided the resident's provid				
	10:30am revealed: -She did not want h -She could not affor strips. Interview with the S 07/01/21 at 10:10ar -She had spoken to about the glucomet -Resident #3 did not checked. Interview with the N Care Provider's (PO	o the pharmacist last week er and strips. of want her blood sugar lurse at Resident #3's Primary CP) office on 07/06/21 at n order was sent to another				

6899

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING		07/0	R 2/2021
		1 02017010			0770	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO	N ROAD		
		BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 249}	Continued From pa	ge 18	{C 249}			
	revealed: -She would like to h not have to pay for -She would check h pay for the supplies Interview with a tect on 07/07/21 at 1:17 -The pharmacy rece glucometer in April 2	ner FSBS if she did not have to hinician at another pharmacy pm revealed: eived an electronic script for a 2021.				
	-The pharmacy attempted to reach the resident without successThe pharmacy no longer provided service to this residentThe pharmacy did not recall notifying the PCP that the order was not filled.					
		e interviews with Resident 21 at 2:00pm and 07/02/21 at cessful.				
	Attempted telephon Administrator on 07 unsuccessful.	e interview with the /02/21 at 12:14pm was				
	for three residents of take FSBS daily (#1) (#2). The facility's far placed the diabetic effects of hyperglyc facility failed to implement blood pressure took medication to learn the resident's becked since admicheck the resident's primary care provide	implement orders for FSBS who had physician's orders to 1, #3) and twice daily FSBS ailure to check the FSBS residents at risk for side emia and hypoglycemia. The ement an order for twice a are checks for a resident who ower her blood pressure (#2) blood pressure had not been ission. The facility's failure to be blood pressure prohibited the er from knowing if the essure was maintained at a				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 19 of 69

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BOILDING.			R	
		FCL017018	B. WING			2/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TAYLOR	FAMILY CARE HOME	· #2	RTHA WILSO , NC 27212	N ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{C 249}	Continued From pa	ige 19	{C 249}				
	therapeutic range. The failure of the facility was detrimental to the health and safety of the residents and constitutes an Unabated Type B Violation. The facility was provided a plan of protection in accordance with G.S. 131D-34 on 07/02/21 for this violation.						
		TE FOR THE TYPE B NOT EXCEED AUGUST 16,					
{C 254}		903(c) Licensed Health ort	{C 254}				
	Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist 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 Rule, is completed within the first 30 days of 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						

Division of Health Service Regulation STATE FORM

TE FORM G899 QLFL12 If continuation sheet 20 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING			R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・サン	RTHA WILSO , NC 27212	N ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETE DATE
{C 254}	Continued From pa	ge 20	{C 254}			
	(1) through (3) of th	is Paragraph.				
	reviews, the facility Licensed Health Pro- evaluation had been health professional (#1, #2, and #3) wit blood sugars (FSBS	ons, interviews, and record failed to ensure a quarterly ofessional Support (LHPS) n completed by a licensed for 3 of 3 sampled residents h an LHPS task of finger stick				
	The findings are:					
	Review of Resident #2's current FL-2 dated 08/05/20 revealed: Diagnoses included schizophrenia, bipolar disorder, adjustment disorder, and altered mental status. There was an order to check finger stick blood sugar (FSBS) twice daily.					
		upervisor-in-Charge (SIC) on revealed Resident #2 was lity on 05/11/21.				
	revealed: -There was no entry FSBS twice daily.	rd (MAR) for June 2021 y to check Resident #2's umentation Resident #2's				
	there was no Licens Support (LHPS) eva Interview with the S revealed:	#2's medical record revealed sed Health Professional aluation available for review. FIC on 07/02/21 at 11:02am It was a nurse and was the				

Division of Health Service Regulation STATE FORM

DRM G899 QLFL12 If continuation sheet 21 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R	
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR FAMILY CARE HOME #2			THA WILSO NC 27212	N ROAD		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
{C 254}	Continued From pa	ge 21	{C 254}			
{C 254}	LHPS nurseResident #2 was number the nurse ware-she did not know I have twice daily FS the nurse to do an Ite-she had contacted and requested an example of the nurse to do an Ite-she had contacted and requested an example of the she had contacted and requested and	not a resident at the facility is last at the facility. Resident #2 was supposed to its so she had not requested LHPS evaluation. If the LHPS nurse on 07/01/21 evaluation for Resident #2. The interview with the facility's large 07/01/21 at 12:02pm was the interview with the 7/02/21 at 12:14pm was lent #1's current FL-2 dated data.	{C 254}			
	2021, March 2021, -There was no entr FSBS dailyThere was no doct FSBS was checked Review of Resident there was no Licens	t #1's MARs for February and April 2021 revealed: y to check Resident #1's umentation Resident #1's t. t #1's medical record revealed sed Health Professional aluation record available for				
	Interview with the S 07/02/21 at 11:02ar -Resident #1 had a	Supervisor-in-Charge (SIC) on m revealed: n LHPS task of FSBS. and completed the LHPS				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 22 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		FCL017018	B. WING			2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・サフ	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 254}	evaluation on Residest survey." -She did not know is completedShe would call the Resident #1's LHPS requested on 07/02 provided prior to exact the provided prior to ex	dent #1 "about a week after the f an LHPS form was LHPS nurse. Sevaluation form was 1/21 at 11:02am was not it on 07/02/21. The interview with the facility's turse 07/01/21 at 12:02pm was not it on 07/02/21 at 12:02pm was not it on 07/02/21. The interview with the facility's turse 07/01/21 at 12:02pm was not interview with the 1/02/21 at 12:14pm was not interview with the 1/02/21 at 12:02pm was not interview with the 1/02/21 at 12:0	{C 254}			
		y to check Resident #3's				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 23 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)			SURVEY LETED	
					R	
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 254}	Continued From pa	ge 23	{C 254}			
	FSBS dailyThere was no docu	umentation Resident #3's l.				
	Review of Resident #3's medical record revealed there was no Licensed Health Professional Support (LHPS) evaluation available for review.					
	07/02/21 at 11:00ar -Resident #3 did no -Resident #3 did no her blood sugars. -She did not ask the	upervisor-in-Charge (SIC) on n revealed: thave any LHPS tasks. thave a glucometer to check the LHPS nurse to assess se she did not receive FSBS.				
		e interview with the facility's urse 07/01/21 at 12:02pm was				
	Attempted telephon Administrator on 07 unsuccessful.	e interview with the //02/21 at 12:14pm was				
{C 270}	10A NCAC 13G .09 Service	04 (c-7) Nutrition And Food	{C 270}			
	10A NCAC 13G .09	04 Nutrition And Food Service				
	Menus in Family Ca	are Homes:				
		have a matching therapeutic ysician-ordered therapeutic of food service staff.				
	reviews, the facility	et as evidenced by: ons, interviews, and record failed to have matching for food service guidance for 3				

Division of Health Service Regulation STATE FORM

G899 QLFL12 If continuation sheet 24 of 69

Division of Health Service Regulation						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	2
		FCL017018	B. WING		07/0	2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 270}	Continued From pa	ge 24	{C 270}			
	orders for a no con-	ents (#1, #2, #3) with physician centrated sweets (NCS) diet rated sweet (LCS) diet (#2), (#3).				
	The findings are:					
	Observation of the breakfast meal service on 07/01/21 at 9:02am revealed: -All the residents were served a bowl of cerealEach bowl contained at least two cups of cereal with milk.					
	Review of the cereal box on 07/01/21 at 12:10pm revealed: -A serving size was 1 cupOne cup contained 12 grams of sugarOne cup contained 30 grams of carbohydrates.					
	Observation of the kitchen on 07/01/21 at 12:10pm revealed: -There was no weekly menu and no therapeutic diet menu posted for staff to followThere was not diet list for the staff to follow.					
	07/02/21 at 11:03ar -She did not have a -She had a regular with diabetesThe menu's had be was preparing to pa -She had the menu -She did not need to because she fixed to served normallyShe did not measu provided to the resi	diet list. menu and one for residents een packed up because she aint in the facility. 's one day last week. he menu to prepare food what the residents were are the amount of cereal dents.				
	1. Review of Reside	ent #2's current FL-2 dated				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 25 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		R 07/02/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	07702	2/2021
		1136 BFR	THA WILSO			
TAYLOR	FAMILY CARE HOME	・サン	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 270}	Continued From pa	ge 25	{C 270}			
	disorder, adjustmer status. -There was an orde sweets (LCS) diet.	d schizophrenia, bipolar nt disorder, and altered mental er for a low concentrated				
	Interview with the Supervisor-in-Charge on 07/02/21 at 11:02am revealed: -Resident #2 was not on a special dietShe did not receive an FL-2 on Resident #2 until a week after the resident was admittedShe probably looked at the diet order but forgotResident #2 was not served sweets.					
	Telephone interview with Resident #2's primary care provider (PCP) on 07/01/21 at 3:56pm revealed: -Resident #2 was ordered a LCS diet and he expected the diet to be followedResident #2 should not have been served two cups of cereal on a LCS dietIf Resident #2 was not served a LCS diet she could become hyperglycemic (elevated blood sugar).					
	Attempted interview at 9:50am was uns	v with Resident #2 on 07/02/21 uccessful.				
		ne interview with the 7/02/21 at 12:14pm was				
	07/07/20 revealed: -Diagnoses include dementia, anxiety,	ent #1's current FL-2 dated d diabetes, Alzheimer's and hypertension. er for a no concentrated				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 26 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		FCL017018	B. WING			R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO	N ROAD		
	0.18.44.574.074		NC 27212		FOTION	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{C 270}	Continued From pa	ge 26	{C 270}			
	revealed: -She was not on a selection of the selection of	what a NCS diet was. was provided for her to eat.				
	Supervisor-in-Charge 11:03am revealed: -Resident #1 was number -She could not read #1's FL-2 for diet.	ot on a special diet. If what was listed on Resident what a NCS diet was and had cation.				
		ne interview with Resident #1's t 4:17pm unsuccessful.				
		ne interview with the 1/02/21 at 12:14pm was				
	07/30/20 revealed of schizophrenia, psycoschizoaffective disc	chosis, tobacco disorder,				
	dated 06/25/21 reve	#3's signed physician's order ealed an order for a low avoid rice, potatoes and white				
	07/01/21 at 8:55am -Resident #3 was s bowl contained at le milk.	breakfast meal served on revealed: erved a bowl of cereal; the east two cups of cereal with				

6899

Division of Health Service Regulation
STATE FORM

QLFL12 If continuation sheet 27 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		F	,
		FCL017018	B. WING		07/02/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・サン	THA WILSO	N ROAD		
	T		NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 270}	O) Continued From page 27		{C 270}			
		n 8-ounce glass of water. Imed 100 percent of meal.				
	Observation of the breakfast meal served on 07/02/21 at 9:20am revealed: -Resident #3 was served eggs, bacon and toastResident #3 was served an 8-ounce glass of					
	orange juice and 8-ounce glass of waterResident #3 consumed 100 percent of meal.					
	Interview with Resident #3 on 07/01/21 at 10:30am revealed:					
	-She was not to eat rice, potatoes, or white breadShe had a blood sugar greater than 300 when her FSBS was checked at the PCP's office on 06/25/21She could go into a diabetic coma if her blood					
	sugar continued to	_				
	Interview with Resident #3 on 07/02/21 at 9:00am revealed: -The resident went to a fast food restaurant for lunch on 07/01/21The resident had a chicken sandwich for lunchThe resident had pizza for dinner from a fast food restaurant on 07/01/21.					
	07/01/21 at 10:10al -Resident #3 was n white bread.	Supervisor-in-Charge on m revealed: ot to eat rice, potatoes or go into a diabetic coma.				
	office on 07/06/21 a -Resident #3 needed due to her diabetes -Resident #3's A1C	rse at Resident #3's PCP's at 1:32 pm revealed; ed to follow her diet as ordered s. (The hemoglobin A1C test age level of blood sugar over				

the past 2 to 3 months. According to the

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 28 of 69

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		3) DATE SURVEY COMPLETED	
					R		
		FCL017018	B. WING		07/0	2/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
TAYLOR	TAYLOR FAMILY CARE HOME #2 BLANCH			N ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE	
{C 270}	Continued From pa	ge 28	{C 270}				
	is a goal for diabeti	a HbgA1C value less than 7.0 c residents with the normal eing 4 to 5.9) was 7.9 on					
	Attempted telephone interviews with Resident #3's PCP on 07/01/21 at 2:00pm and 07/02/21 at 9:35am were unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.						
C 320	10A NCAC 13G .10	002 (f) Medication Orders	C 320				
	10A NCAC 13G .10	Medication Orders					
	(f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months						
	reviews, the facility orders for medication reviewed and signer or prescribing pract	et as evidenced by: ons, interviews, and record failed to ensure all current ons and treatments were d by the resident's physician itioner at least every six ampled residents (#1and #3).					
	The findings are:						
	07/07/20 revealed: -Diagnoses include anxiety, diabetes, a	ent #1's current FL-2 dated d Alzheimer's dementia, nd hypertension. er for Metoprolol tartrate 25mg					

Division of Health Service Regulation STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R		
		FCL017018	B. WING		07/0	2/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
TAYLOR	FAMILY CARE HOME	· #2	THA WILSO	N ROAD			
	OLUMBA DV OTA	·	NC 27212		211		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 320	Continued From pa	ge 29	C 320				
C 320	(used to treat hyper-There was an order (antipsychotic) taken - There was an order (nutritional supplementer - There was an order (antidepressant) taken - There was an order to treat high choles - There was an order to treat high choles - There was an order to treat anxiety) taken - There was an order to lower cholesteror - There was an order to treat nerve pain) - There was an order to treat nerve pain) - There was an order to treat nerve pain) - There was an order to treat anxiety) taken - There was an order to treat anxiety) taken - There was an order to treat anxiety) taken - There was an order to treat anxiety) taken - There was an order to treat anxiety taken - There was an order some tablet daily There was an order slow the progression twice daily.	rtension) take one tablet daily. For for Risperdal 1mg one tablet twice daily. For for Vitamin D 1000 units nent) daily. For for Venlafaxine 100mg ke ½ tablet twice daily. For for Aspirin 81mg (blood ablet daily. For Atorvastatin 80mg (used terol) take one tablet daily. For for Buspirone 5mg (used to one tablet three times daily. For for Calcium antacid tablet dieve heartburn) take one tablet daily. For for Gabapentin 300mg (used that the tablet at bedtime. For for Lamotrigine 200mg for Lamotrigine 200mg for disorder) take one tablet at bedtime and as for Lorazepam 0.5mg (used the one tablet at bedtime and as for Lorazepam 10mg (used the one tablet at bedtime and as for Lorazepam 10mg (used to one of dementia) take one tablet take at high blood pressure) take one tablet tablet at #1's Resident Register admitted to the facility August	C 320				
	Review of Resident	t #1's medical record revealed nonth signed physician's					

Division of Health Service Regulation STATE FORM

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
					R	
		FCL017018	B. WING	<u></u>	07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	· #2	THA WILSO	N ROAD		
(V4) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	NC 27212	PROVIDER'S PLAN OF CORRECTION	ON N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 320	Continued From pa	ige 30	C 320			
	Refer to the intervie Supervisor-in-Char 9:20am.	ew with the ge (SIC) on 07/02/21 at				
	2. Review of Resident #3's current FL2 dated 07/30/20 revealed diagnoses included schizophrenia, psychosis, tobacco disorder, schizoaffective disorder, bipolar type, hypertension, diabetes type 2, hyperlipidemia.					
	dated 07/31/20 revi-There was an order thinner) 81 mg daily-There was an order to treat involuntary stiffness) 50mg three was an order diabetes) 10mg daily-There was an order anti-psychotic medical day. There was an order as a supplement) 4-There was an order diabetes) 1000mg for There was an order lower cholesterol) 4-There was an order lower cholesterol	er for aspirin (used as a blood by. er for diphenhydramine (used movements and muscle ee times a day. er for glipizide (used to treat lily before breakfast. er for iloperidine (an ication) 10mg three times a ler for lisinopril (used to treat le) 20mg daily. er for magnesium oxide (used 100mg daily. er for metformin (used to treat le) refor metformin (used to treat le) 20mg daily.				
		t #3's medical record revealed nonths physician order				

Division of Health Service Regulation STATE FORM

6899 QLFL12 If continuation sheet 31 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		FCL017018	B. WING			2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	- サン	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 320	Continued From page 31		C 320			
	renewals of all medications and treatments prescribed since admission. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. Refer to the interview with Supervisor-in-Charge (SIC) on 07/02/01 at 9:20am.					
	Interview with SIC on 07/02/21 at 9:20am revealed: -The residents were seen by their PCP every six months. -The SIC did not know why the signed physician orders were not in the medical record. -She knew she was supposed to obtain signed physician's orders every six months. -She had never requested a copy of the resident's medication administration record (MAR) to send to the providers.					
{C 330}	10A NCAC 13G .10 Administration	004(a) Medication	{C 330}			
	(a) A family care he preparation and ad prescription and no by staff are in acco (1) orders by a licer which are maintained.	004 Medication Administration ome shall assure that the ministration of medications, on-prescription and treatments rdance with: nsed prescribing practitioner ed in the resident's record; and ction and the facility's policies				
		et as evidenced by: YPE B VIOLATION				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 32 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		FCL017018	B. WING			2/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・ 世ク	RTHA WILSO , NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ige 32	{C 330}			
	Based on these find Violation was not a	dings, the previous Type B bated.				
	reviews, the facility medications as ord residents (#1, #2 an antipsychotic medic	ions, interviews, and record failed to administer ered for 3 of 3 sampled and #3) related to an cation (#1), a medication used ects of antipsychotic d a sedative (#3).				
	The findings are:					
	1. Review of Resident #3's current FL-2 dated 07/30/20 revealed diagnoses included schizophrenia, psychosis, tobacco disorder, schizoaffective disorder, bipolar type, hypertension, diabetes type 2, hyperlipidemia.					
	09/18/20 revealed a	t #3's physician's order dated an order to decrease lative used to treat insomnia)				
	administration reco -There was an elec 30mg daily with a s of 8:00pm.	t #3's April 2021 medication rd (MAR) revealed: stronic entry for Temazepam cheduled administration time written entry to change				
	Temazepam to 15n administration time -There was a hand-changed to 15mg a -There was no door was administered.	ng daily with a scheduled of 8:00pmwritten entry for Temazepam at bedtime dated 09/18/20. umentation Temazepam 15mg				
	Review of Resident	t #3's May 2021 MAR				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 33 of 69

DIVISION	Division of Health Service Regulation							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		FCL017018	B. WING		R 07/02/2021			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
		1136 BFR	THA WILSO					
TAYLOR FAMILY CARE HOME #2		NC 27212						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE		
{C 330}	Continued From page 33		{C 330}					
	revealed: -There was an elect 30mg daily with a sof 8:00pmThere was a hand-changed to 15mg and an elect 30mg daily with a sof 8:00pmThere was docume was administered 8 Review of Resident revealed: -There was an elect 30mg daily with a sof 8:00pmThere was a hand-changed to 15mg and an elect 30mg daily with a sof 8:00pmThere was a hand-changed to 15mg and an elect 30mg daily with a sof 8:00pmThere was a hand-changed to 15mg and an elect 30mg daily with a sof 8:00pmThere was no doct was administeredThere was no doct was administered and administered and administered and administered and all the electron electrons and an electron electrons and an electron electrons and an electron electrons and an electron electrons and all the electrons and ele	tronic entry for Temazepam cheduled administration time ewritten entry for Temazepam t bedtime on 09/18/20. Temazepam 15mg entation Temazepam 30mg entation Temazepam 30mg entation Temazepam 30mg entation Temazepam administration time ewritten entry for Temazepam theduled administration time ewritten entry for Temazepam to bedtime on 09/18/20. Temazepam 15mg entation Temazepam 30mg the 8:00pm. Which with a Pharmacist at the pharmacy on 07/01/21 at fived on 08/03/20 for Resident 10mg; thirty tablets were 13/20. The was dispensed on 08/27/20 and 15mg the pharmacy on 15mg. Temazepam 15m						

Interview with the Supervisor-in-Charge on
Division of Health Service Regulation
STATE FORM

6899 QLFL12 If continuation sheet 34 of 69

					(X3) DATE SURVEY COMPLETED	
	FCL017018		B. WING		R 07/02/2021	
<u> </u>					1 07/0	2/2021
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S T HA WILSO I	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	NC 27212	NICAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ge 34	{C 330}			
	07/02/21 at 9:10am revealed she did not know Resident #3's Temazepam 15mg was not in the multi-dose packet of night medications.					
	Attempted telephone interviews with Resident #3's PCP on 07/01/21 at 2:00pm and 07/02/21 at 9:35am were unsuccessful.					
	Attempted telephon Administrator on 07 unsuccessful.	e interview with the //02/21 at 12:14pm was				
	 2. Review of Resident #2's current FL-2 dated 08/05/20 revealed: -Diagnoses included schizophrenia, bipolar disorder, adjustment disorder, and altered mental status. -There was an order for Austedo 12mg twice daily. (Austedo is used to decrease involuntary movements of the face, tongue, or other body parts). 					
	Supervisor-in-Charghave a May 2021 m	record and interview with the ge (SIC) Resident #2 did not nedication administration able to be reviewed.				
	revealed: -There was an entry with a scheduled ac and 8:00pmAustedo 12mg was from 06/01/21-06/36	#2's MAR for June 2021 y for Austedo 12mg twice daily dministration time of 8:00am s documented as administered 0/21 at 8:00am and 8:00pm. #2's MAR for July 2021				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 35 of 69

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	FCL017018				F 07/0	2/2021
NAME OF 1					0770	2/2021
NAME OF I	PROVIDER OR SUPPLIER		THA WILSO	STATE, ZIP CODE		
TAYLOR FAMILY CARE HOME #2			NC 27212	NKOAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ge 35	{C 330}			
	-There was an entry with a scheduled and 8:00pmAustedo 12mg was on 07/01/21 at 8:00 Observation of Resform dated 05/11/2 tablets of Austedo 7 previous facility to the Review of Resident 07/01/21 at 11:48ar -There was a presodispensed on 04/16 -There were 11 table administered.	y for Austedo 12mg twice daily dministration time of 8:00am is documented as administered fam and 8:00pm. Ident #2's medication release 1 revealed Resident #2 had 32 12mg transferred from her his facility. If #2's medications on hand on m revealed: Interpretation of Austedo 12mg 6/21 for 60 tablets.				
	Review of Resident #2's medications on hand on 07/02/21 at 8:33am revealed: -There was a prescription bottle of Austedo 12mg dispensed on 04/16/21 for 60 tabletsThere were 11 tablets available to be administered.					
	administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 07/01/21 at 1:31pm revealed: -The SIC contacted her on 05/28/21 and requested a refill on Resident #2's Austedo 12mg. -She wanted to make sure the Austedo for Resident #2 was covered by the residents' insurance and therefore only provided the facility with a "couple of days" of Austedo in a punch card while waiting on the insurance approval. -On 05/31/21, the remainder of a months' worth of Austedo 12mg was dispensed. -There were no extra tablets of Austedo 12mg					

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		FCL017018	B. WING		07/0	? 2/2021
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0170	2/2021
TAYLOR	FAMILY CARE HOME	#2	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 330}	dispensed in a punc-On 06/25/21, the SResident #2's medi 12mgA 4-day supply of A in a punch card on Observation of Res 11:00am revealed: -The SIC was chec pressureResident #2 was hher armThe SIC told Resid Interview with Resid revealed: -Without opening hedepressed, and I ar -She would not respond to the prescripti -She administered #2's Austedo 12mg -She thought she arout of the prescripti -She did not know to on 07/01/21 and 07 -She may have only on 07/02/21 becaus was once a dayWhen she read the	lity, a total of 60-tablets were ch card. ICC requested refills on cations, including the Austedo Austedo 12mg was dispensed 06/25/21. ident #2 on 07/01/21 at king Resident #2's blood aving an involuntary jerking in lent #2 to "quit shaking." dent #2 on 07/02/21 at 9:50am er eyes, she stated, "I am not talking." bond to any other questions. upervisor-in-Charge (SIC) on revealed: and documented Resident last night, 07/01/21. dministered the Austedo 12mg on bottle. why the count was the same /02/21. If administered Austedo once se she thought the medication apparametry label on the	{C 330}			
	tablet" she did not s	n bottle, she saw "take one see the twice a day. he interview with Resident #2's der on 07/01/21 at 4:58pm				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 37 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
					F	₹
		FCL017018	B. WING			2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	RTHA WILSO	N ROAD		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	, NC 27212	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
{C 330}	Continued From pa	ge 37	{C 330}			
	Attempted telephon Administrator on 07 unsuccessful.	ne interview with the 7/02/21 at 12:14pm was				
	07/07/20 revealed of	ent #1's current FL-2 dated diagnoses included diabetes, tia, anxiety and hypertension.				
	07/07/20 revealed a	#1's physician's order dated an order for Buspirone HCL cation used to treat anxiety) ily.				
	administration reco -There was an entry times daily with a so of 8:00am, 12:00pn -There was docume administered at 8:0 on 05/01/21-05/10/2 -Buspirone 5mg wa	y for Buspirone 5mg three cheduled administration time in and 8:00pm. entation Buspirone 5mg was 0am, 12:00pm, and 8:00pm 21. is not documented as				
	-Buspirone 5mg wa administered at 8:0 05/11/21-05/26/21 a -Buspirone 5mg wa	00pm from 05/11/21-05/26/21. is documented as 0am and 8:00pm on and at 8:00am on 05/27/21. is not documented as /27/21 at 12:00pm and				
	-Buspirone 5mg wa administered on 05 -Sixty-three tablets documented as adr sixty-three tablets w	is not documented as /28/21-05/31/21. of Buspirone 5mg were ministered; thirty nine of the vere documented as the notation of the notation of the vere documented as the notation of the notation				
	revealed:	#1's June 2021 MAR y for Buspirone 5mg three				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 38 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
					F	₹
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSOI NC 27212	N ROAD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
{C 330}	Continued From pa	ge 38	{C 330}			
	of 8:00am, 12:00pn -There was docume	entation Buspirone 5mg was 0am, 12:00pm, and 8:00pm 21. uspirone 5mg were				
	on 07/01/21 at 11:4 -There was a punch 5mg take one table on 05/08/21 with 12 administeredThere were three p HCL 5mg take one	n card labeled Buspirone HCL t three times daily dispensed 2 of 90 tablets available to be bunch cards labeled Buspirone tablet three times daily //21 with 90 of 90 tablets				
	on 07/01/21 at 2:58 -Resident #1's Busy medication and was -Resident #1's Busy 05/08/21 for 90 tabl tablets and was on 07/20/21 for 90 tabl -Resident #1's Busy 05/08/21 for 90 tabl up on 05/08/21 and dispensing for 06/08/21/21.	birone 5mg was a cycle filled is dispensed every 30-days. Dirone 5mg was filled on lets and 06/21/21 for 90 schedule to be filled on lets. Dirone 5mg dispensed on lets was most likely not picked therefore the scheduled 8/21 was bumped forward until mere should be "that many"				
	dispensing records, Resident #1 from 0 of Buspirone were	on of medications on hand, , and record review for 5/09/21-07/01/21, 129 tablets documented as administered; peen 51 of 180 Buspirone				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 39 of 69

DIVIDION	Division of Health Service Regulation					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAIN	O. JOHNLOHON	IDENTIFICATION NUMBER.	A. BUILDING:			
		FOL 047040	B. WING		F 07/0	
		FCL017018	B. WINO		07/0	2/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO	N ROAD		
	I		NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ge 39	{C 330}			
	tablets remaining; 1	02 tablets were left on hand.				
	07/02/21 at 11:33ar -Resident #1's Busy times a dayResident #1's 12:0 administered at 12: 2:00pmShe did not know w medications on han medication was adr -Resident #1 had no she may not have de	upervisor-in-Charge (SIC) on n revealed: birone was administered three Opm may not have been Oopm but was administered by why there were more ad than should have been if the ministered three times a day. Ot ran out of her medications, locumented administering irone but the medication was				
	10:06am revealed: -She took medication and dinnerShe did not take monly in the morning -She did not remember medications at a she linear the she did not remember medications at a she felt anxiousShe got a "nervous and walk aroundShe did not remember way, but it had beer she had not been she had a headact woke upShe had not told at she she took and told and t	the end of May 2021. Ident #1 on 07/02/21 at 9:28am Is feeling" and had to get up The when she last felt this This week." It this way every day.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		FOI 047040	B. WING		F	
		FCL017018	D. WINO		07/0	2/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ge 40	{C 330}			
		e interviews with Resident 21 at 4:17pm unsuccessful.				
	Attempted telephon Administrator on 07 unsuccessful.	e interview with the 1/02/21 at 12:14pm was				
	ordered for 3 of 3 si #3) who was not ad ordered including m #3; and an anti-psycordered to be admir was only administer who had experience medication used to anti-psychotic medi movement and was involuntary movement failure of the facility ordered was detrim	administer medications as ampled residents (#1, #2, and ministered medications as nedication to treat insomnia chotic medication that was nistered three times a day and red twice daily for a resident ed feeling anxious (#1); and a treat the side effects of cation including involuntary anoted to be experiencing ent on 07/01/21 (#2). The to administer medications as ental to the health, safety, and ents and constitutes an iolation.				
		vided a plan of protection in S. 131D-34 on 07/02/21 for				
		TE FOR THE TYPE B . NOT EXCEED AUGUST 16,				
{C 342}	10A NCAC 13G .10 Administration	04(j) Medication	{C 342}			
	(j) The resident's m	04 Medication Administration nedication administration be accurate and include the				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 41 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R	
		FCL017018	B. WING			2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・ 世フ	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 342}	(3) strength and do medication adminis (4) instructions for a or treatment; (5) reason or justific medications or treat documenting the redocumenting the redocumenting the redocumentation of medications or treat omission, including (8) name or initials the medication or training the medication reconstruction. This Rule is not medicated and madministration reconstruction. The findings are: 1. Review of Residual to 1. Review of Residual training tra	dication or treatment order; beage or quantity of stered; administering the medication cation for the administration of the atments as needed (PRN) and esulting effect on the resident; of administration; of any omission of the nerts and the reason for the refusals; and of the person administering reatment. If initials are used, a at to those initials is to be naintained with the medication	{C 342}			

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 42 of 69

NAME OF PROVIDER OR SUPPLIER TAYLOR FAMILY CARE HOME #2 SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (CA4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) - There was an order for Divalproex 500mg take two tablets twice a day. (Divalproex is used to treat depression). - There was an order for Linzess 145mcg take one tablet daily (Linzess is used to treat hypothyroidism). - There was an order for Lithium Carb 300mg take one tablet at bedtime (Lithium is used to treat bipolar disorders). - There was an order for Lithium Carb 300mg take one tablet at bedtime (Lithium is used to treat bipolar disorders). - There was an order for Metoprolol Tartrate 25mg take one tablet twice daily (Metformin 500mg take one tablet twice daily (Met	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	STATEMENT
NAME OF PROVIDER OR SUPPLIER TAYLOR FAMILY CARE HOME #2 1136 BERTHA WILSON ROAD BLANCH, NC 27212 (X4) ID PREFIX TAG (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) ATTAG (X6) ATTAG (X7) ATTAG (X8) Continued From page 42		
TAYLOR FAMILY CARE HOME #2 CAJ ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGK (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	FCL017018	
Cart Summary statement of Deficiencies Summary statement of Deficiencies Prefix Regulatory or List Deficiency must be preceded by full Prefix Tag Regulatory or List Dentifying information) Prefix Tag Providers plan of Correction (Each Deficiency must be preceded by full Regulatory or List Deficiency Deficiency Deficiency Deficiency Date Date Deficiency Date Date Deficiency Date	IAME OF PROVIDER OR SUPPLIER STREET	NAME OF P
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (C 342) (TAYLOR FAMILY CARE HOME #2	TAYLOR F
Cach deficiency Must be Preceded By Full Regulatory or Lsc Identifying Information Prefix Tag Cross-Referenced to 1 the Appropriate Complete Cross-Referenced to 1 the Appropriate Case Ca		
antipsychotic medication). -There was an order for Divalproex 500mg take two tablets twice a day. (Divalproex is used to treat bipolar disorders). -There was an order for Escitalopram 10mg take one tablet daily (Escitalopram is used to treat depression). -There was an order for Levothyroxine 50mg take one tablet daily (Levothyroxine is used to treat hypothyroidism). -There was an order for Linzess 145mcg take one tablet daily (Linzess is used to treat constipation). -There was an order for Lithium Carb 300mg take one tablet at bedtime (Lithium is used to treat bipolar disorders). -There was an order for Metformin 500mg take one tablet twice daily (Metformin is used for the treatment of diabetes). -There was an order for Metoprolol Tartrate 25mg	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PRÉFIX
-There was an order for Divalproex 500mg take two tablets twice a day. (Divalproex is used to treat bipolar disorders). -There was an order for Escitalopram 10mg take one tablet daily (Escitalopram is used to treat depression). -There was an order for Levothyroxine 50mg take one tablet daily (Levothyroxine is used to treat hypothyroidism). -There was an order for Linzess 145mcg take one tablet daily (Linzess is used to treat constipation). -There was an order for Lithium Carb 300mg take one tablet at bedtime (Lithium is used to treat bipolar disorders). -There was an order for Metformin 500mg take one tablet twice daily (Metformin is used for the treatment of diabetes). -There was an order for Metoprolol Tartrate 25mg	{C 342} Continued From page 42	{C 342}
used to treat hypertension). -There was an order for Oxybutynin 5mg take two tablets daily (Oxybutynin is used to treat an overactive bladder). -There was an order for Vitamin D2 50,000 units take one tablet once a week (Vitamin D is a nutritional supplement). Based on review of record and interview with the Supervisor-in-Charge (SIC) Resident #2 did not have a May 2021 medication administration record (MAR) available to be reviewed. Review of Resident #2's July 2021 MAR revealed: -There was one page available to be reviewedThere was no entry for Clozapine 10mg take one tablet at bedtime.	antipsychotic medication). -There was an order for Divalproex 500mg take two tablets twice a day. (Divalproex is used to treat bipolar disorders). -There was an order for Escitalopram 10mg take one tablet daily (Escitalopram is used to treat depression). -There was an order for Levothyroxine 50mg tak one tablet daily (Levothyroxine is used to treat hypothyroidism). -There was an order for Linzess 145mcg take one tablet daily (Linzess is used to treat constipation). -There was an order for Lithium Carb 300mg tak one tablet at bedtime (Lithium is used to treat bipolar disorders). -There was an order for Metformin 500mg take one tablet twice daily (Metformin is used for the treatment of diabetes). -There was an order for Metoprolol Tartrate 25mg take ½ tablet twice daily (Metoprolol Tartrate is used to treat hypertension). -There was an order for Oxybutynin 5mg take two tablets daily (Oxybutynin is used to treat an overactive bladder). -There was an order for Vitamin D2 50,000 units take one tablet once a week (Vitamin D is a nutritional supplement). Based on review of record and interview with the Supervisor-in-Charge (SIC) Resident #2 did not have a May 2021 medication administration record (MAR) available to be reviewed. Review of Resident #2's July 2021 MAR revealed. -There was no entry for Clozapine 10mg take on	

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 43 of 69

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		-0 104-040	R WING		F	
		FCL017018	B. WING		07/0	2/2021
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO	N ROAD		
	OLIMAN AND VIOLA		NC 27212	DDO//IDEDIO DI AN OF CODDECTIO	N	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 43	{C 342}			
	-There was no entry tablets daily.	y for Oxybutynin 5mg take two				
	07/02/21 at 10:32ar -She had not notice from Resident #2's -She administered I medication last nigh -She did not docum #2's May 2021 med did not have a MAR -She administered I transferred with the (05/11/21) using the was dispensed in. Attempted telephon Administrator on 07 unsuccessful. 2. Review of Reside 07/07/20 revealed of	d there was a page missing July 2021 MAR. Resident #2's bedtime at, 07/01/21. ent administering Resident ications because the resident for May 2021. The medications that were resident at admission e punch cards the medication				
	a. Review of Reside	ent #1's physician's orders ealed there was an order for 25mg (used to treat				
	administration recolution - There was an entry twice daily with a scanned and 5:00pm - There was no documant was administered of - There was no document of the scanned and th	y for Metoprolol Tartrate 25mg cheduled administration time of				

6899

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		FCL017018	B. WING			R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO	N ROAD		
	T	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPROPRIEM (PROSS-REFERENCE)	OULD BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 44	{C 342}			
{C 342}	Interview with the S 07/02/21 at 10:32ar - She did not know on Resident #1's Madministered 05/27 - She administered finissed" documenting Attempted telephone Administrator on 07 unsuccessful. b. Review of Resident dated 07/07/20 reversiperidone 1mg (atwice daily. Review of Resident administration recording with a schedul 8:00am and 5:00pm - There was an entry daily with a schedul 8:00am and 5:00pm - There was no document administered on 05 - There was no document on 05 - The did not know on Resident #1's Madministered 05/27 - She administered in missed" documenting Attempted telephone	supervisor-in-Charge (SIC) on m revealed: why she had not documented AR for medications //21-05/21/21. the medication, she "just ng the medication. The interview with the medication was an order for antipsychotic) take one tablet at #1's May 2021 medication and (MAR) revealed: my for Risperidone 1mg twice and administration time of an mentation Risperidone was mentation Risperid	{C 342}			
	unsuccessful. c. Review of Reside	ent #1's physician's orders				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 45 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		E SURVEY PLETED
		FCL017018	B. WING			R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSOI NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 45	{C 342}			
		ealed there was an order for ts (nutritional supplement)				
	administration reco -There was an entro once daily with a so 8:00am.	y for Vitamin D3 1000 units heduled administration time of umentation Vitamin D3 was				
	07/02/21 at 10:32ar -She did not know v on Resident #1's M administered 05/27	why she had not documented AR for medications /21-05/21/21. the medication, she "just				
	Attempted telephor Administrator on 07 unsuccessful.	e interview with the //02/21 at 12:14pm was				
	dated 07/07/20 reve	ent #1's physician's orders ealed there was an order for tic used to prevent yeast ly				
	administration reco -There was an entry with a scheduled ad	y for Acidophilus once daily Iministration time of 8:00am. umentation Acidophilus was				
	07/02/21 at 10:32ar	vhy she had not documented				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 46 of 69

DIVISION	of Health Service Re	guiation					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING			R 07/02/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TAY 00	EARLY CARE HOME	1136 BEF	RTHA WILSO	N ROAD			
IAYLOR	FAMILY CARE HOME	BLANCH	NC 27212				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 342}	Continued From pa	ge 46	{C 342}				
	administered 05/27 -She administered of missed" documenti	the medication, she "just					
	Attempted telephor Administrator on 07 unsuccessful.	ne interview with the 7/02/21 at 12:14pm was					
	dated 07/07/20 reve	ent #1's physician's orders ealed there was an order for I to prevent strokes) once daily					
	administration reco -There was an entry with a scheduled ad	y for Aspirin 81mg once daily dministration time of 8:00am. umentation Aspirin was					
	07/02/21 at 10:32ar -She did not know on Resident #1's M administered 05/27	why she had not documented AR for medications /21-05/21/21. the medication, she "just					
	Attempted telephon Administrator on 07 unsuccessful.	ne interview with the 1/02/21 at 12:14pm was					
	dated 07/07/20 reve	ent #1's physician's orders ealed there was an order for (used to treat high cholesterol) y.					
	administration reco	#1's May 2021 medication rd (MAR) revealed: v for Atorvastatin 80mg once					

daily with a scheduled administration time of

STATE FORM 6899 QLFL12 If continuation sheet 47 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION		SURVEY PLETED
					ı	₹
		FCL017018	B. WING		07/0)2/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・ 世フ	RTHA WILSO , NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{C 342}	administered on 05 Interview with the S 07/02/21 at 10:32ar -She did not know on Resident #1's M administered 05/27 -She administered missed" documenti Attempted telephor Administrator on 07 unsuccessful. g. Review of Resident dated 07/07/20 revolution of Resident 10mg (undaily). Review of Resident administration reconstruction reconstruction of the series with a schedul 8:00amThere was an entral daily with a schedul 8:00amThere was no doct administered on 05 Interview with the Successful on Resident #1's M administered 05/27 -She administered missed" documenti	umentation Atorvastatin was 1/27/21-05/31/21. Supervisor-in-Charge (SIC) on m revealed: why she had not documented IAR for medications 1/21-05/21/21. the medication, she "just ng the medication. The interview with the 1/02/21 at 12:14pm was 1/21-14pm was 1/21-05/31/21. Supervisor-in-Charge (SIC) on m revealed: why she had not documented IAR for medication, she "just 1/21-05/21/21. The medication, she "just 1/21-05/21/21. The medication, she "just 1/21-05/21/21. The medication, she "just 1/21-05/21/21.	{C 342}			

Division of Health Service Regulation STATE FORM

M QLFL12 If continuation sheet 48 of 69

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING			R 02/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE	•		
TAYL OR	FAMILY CARE HOME	#2	RTHA WILSO	N ROAD			
IAILOR	TAMILI GARL HOME	BLANCH	, NC 27212				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
{C 342}	Continued From pa	ge 48	{C 342}				
	h. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Fenofibrate 145mg (used to lower cholesterol) take one tablet daily.						
	Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Fenofibrate 145mg once daily with a scheduled administration time of 8:00amThere was no documentation Fenofibrate was administered on 05/28/21-05/31/21.						
	Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 10:32am revealed: -She did not know why she had not documented on Resident #1's MAR for medications administered 05/27/21-05/21/21She administered the medication, she "just missed" documenting the medication.						
	Attempted telephon Administrator on 07 unsuccessful.	ne interview with the 7/02/21 at 12:14pm was					
	dated 07/07/20 reve	nt #1's physician's orders ealed there was an order for n 50mg take one tablet daily.					
	administration reco -There was an entry 50mg once daily wi time of 8:00am.	y for Losartan Potassium th a scheduled administration umentation Losartan					
	Interview with the S	upervisor-in-Charge (SIC) on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING			R 02/2021
	PROVIDER OR SUPPLIER FAMILY CARE HOME	1136 BFF	DDRESS, CITY, ST			
IAILUK	PAWILI CARE HOWE	BLANCH	, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{C 342}	07/02/21 at 10:32ar-She did not know on Resident #1's M administered 05/27-She administered missed" documenti Attempted telephor Administrator on 07 unsuccessful. j. Review of Resided dated 07/07/20 reverses buspirone 5mg (ustablet three times did administration recorporations daily with a series of 8:00am, 12:00pm -There was an entritimes daily with a series of 8:00am, 12:00pm -There was no document administered on 05 12:00pm and 5:00properside on 05 12:00pm and 5:00ppoppoppoppoppoppoppoppoppoppoppoppopp	m revealed: why she had not documented AR for medications /21-05/21/21. the medication, she "just ng the medication. the interview with the r/02/21 at 12:14pm was Int #1's physician's orders ealed there was an order for ed to treat anxiety) take one aily. ##1's May 2021 medication rd (MAR) revealed: y for Buspirone 5mg three cheduled administration time in and 5:00pm. Jumentation Buspirone was /28/21-05/31/21 at 8:00am, im. Jumentation Buspirone was /11/21-05/27/21 at 12:00pm. Supervisor-in-Charge (SIC) on m revealed: why she had not documented AR for medications /21-05/21/21. the medication, she "just"	{C 342}			
	Interview with the S 07/02/21 at 10:32aı	supervisor-in-Charge (SIC) on merevealed:				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7t. BOILDING.			R
	FCL	_017018	B. WING			02/2021
NAME OF PROVIDER OR SUPP	ER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR FAMILY CARE HOME #2			THA WILSO NC 27212	N ROAD		
PREFIX (EACH DEFICI		DEFICIENCIES PRECEDED BY FULL /ING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
on Resident #1 administered 0 -She administered in docum Attempted telepy Administrator of unsuccessful. k. Review of Redated 07/07/20 Gabapentin 30 take one tablet Review of Residential administration of the tablet Review of Residential with a schell 8:00am, 12:00p there was an administered of the tablet of tablet of the tablet of tablet of the tablet of tablet o	wwhy she has MAR for me /27/21-05/21 at the medicenting the me none interviee o7/02/21 at sident #1's played to at bedtime. ent #1's May ecord (MAR) ntry for Gabarduled adminmand 5:00 procumentation 05/27/21-05 at Supervisor 2 am revealed why she has MAR for me /27/21-05/21 at the medicenting the me none interviee o7/02/21 at ident #1's phrevealed thermg (used to	/21. pation, she "just edication. w with the 12:14pm was hysician's orders e was an order for treat nerve pain) / 2021 medication revealed: apentin three times istration time of m. n Gabapentin was //31/21. -in-Charge (SIC) on d: ad not documented edications //21. pation, she "just edication. w with the 12:14pm was nysician's orders re was an order for treat bipolar	{C 342}	DEL ROILNOT)		

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 51 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING			R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	TAYLOR FAMILY CARE HOME #2 1136 BE BLANCH			N ROAD		
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COI	PRECTION	(УГ)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 51	{C 342}			
	administration recording administration recording with a schedul 8:00pm. There was no docuadministered on 05. Interview with the S 07/02/21 at 10:32ar. She did not know on Resident #1's Madministered o5/27. She administered is missed" documentification of 07.	y for Lamotrigine 200mg once ed administration time of umentation Lamotrigine was /27/21-05/31/21. upervisor-in-Charge (SIC) on m revealed: why she had not documented AR for medications /21-05/21/21. the medication, she "justing the medication.				
	o7/30/20 revealed of schizophrenia, psychizoaffective disconsisted in the schizophrenia, psychological schizophrenia, psychizophrenia, psychiz	chosis, tobacco disorder, order, bipolar type, oftes type 2, hyperlipidemia. Lent #3's physician's order ealed an order to decrease ative used to treat insomnia) Lent #3's April 2021 medication ord (MAR) revealed: tronic entry for Temazepam cheduled administration time Lent #3's April 2021 medication ord (MAR) revealed: tronic entry for Temazepam cheduled administration time Lent #3's April 2021 medication ord (MAR) revealed: tronic entry for Temazepam cheduled administration time				

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					F	2
FCL017018		B. WING		07/0	2/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYL OR	TAYLOR FAMILY CARE HOME #2			N ROAD		
BLANCH			NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 52	{C 342}			
	changed to 15mg at bedtime dated 09/18/20. -There was no documentation Temazepam 15mg was administered. -There was not documentation Temazepam 30mg was administered at 8:00pm as scheduled.					
	Review of Resident #3's May 2021 MAR revealed: -There was an electronic entry for Temazepam 30mg daily with a scheduled administration time of 8:00pmThere was a hand-written entry for Temazepam changed to 15mg at bedtime on 09/18/20There was no documentation Temazepam 15mg was administeredThere was documentation Temazepam 30mg was administered 8:00pm as scheduled.					
	Review of Resident #3's June 2021 MAR revealed: -There was an electronic entry for Temazepam 30mg daily with a scheduled administration time of 8:00pm. -There was a hand-written entry for Temazepam changed to 15mg at bedtime on 09/18/20. -There was no documentation Temazepam 15mg was administered. -There was documentation Temazepam 30mg was administered at 8:00pm as scheduled. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/01/21 at 2:11pm revealed: -An order was received on 08/03/20 for Resident #3's Temazepam 30mg; thirty tablets were					
	for 30-tablets.	was dispensed on 08/27/20 Ils left on Resident #3's				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 53 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	FCL017018	B. WING			R 02/2021	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TAYLOR FAMILY CARE HOME #2	· ·	THA WILSOI NC 27212	N ROAD			
PREFIX (EACH DEFICIENCY MI	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
order as per the review prescription for Temaz-No one from the facil the Temazepam 15mg. Interview with the Sup 07/02/21 at 9:10am received the revealed there was an to treat diabetes) 1000. Review of Resident #3 there was an entry for tablets twice a day, with administration time of metformin was not do on 4/30/21 at 8:00pm. Review of Resident #3 there was an entry for tablets twice a day, with administration time of metformin was not do on 4/30/21 at 8:00pm. Review of Resident #3 there was an entry for tablets twice a day, with administration time of metformin was not do on 07/01/21 at 8:00pm. C. Review of Resident hand written, signed point (used as a blood thing 03/26/21). Review of Resident #3 and July 2021 MARs in for aspirin 81mg daily. Telephone interview with the signed point and	ot receive the physician's aw dated 09/18/20 or a zepam 15mg. lity called to inquire about g. pervisor-in-Charge on evealed she did not know epam 15mg was not in hight medications. It #3's FL-2 dated 07/30/20 or order for metformin (used 0mg twice daily. 3's April 2021 MAR revealed or metformin 500mg, two ith a scheduled for metformin 500mg, two ith a scheduled or metformin 500mg, two ith a scheduled for metformin 500mg, two ith a scheduled	{C 342}				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			LETED
					R	
		FCL017018	B. WING			2/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYI OR	FAMILY CARE HOME	#2	THA WILSO	N ROAD		
IAILON	TAMET GARETIONE	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 54	{C 342}			
	aspirin 81mg daily f -They would receive from the doctor and	e medication orders by fax I the facility.				
	d. Review of Resident #3's April 2021 MAR revealed there was an entry for benztropine (used to treat tremors) 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm; Benztropine 1mg was not documented as administered on 04/14/21 and 04/30/21 at 8:00pm.					
	Review of Resident #3's July 2021 MAR revealed there was an entry for benztropine 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm; benztropine 1mg was not documented as administered on 07/01/21 at 8:00pm.					
	Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/01/21 at 2:11pm revealed: -The pharmacy had an order for benztropine 1mg twice a day dated 08/03/2021 for Resident #3They would receive medication orders by fax from the doctor and the facility.					
	revealed: -There was an entry schizophrenia) 3mg scheduled administ and 8:00pmRisperidone 3mg vadministered on 04	ent #3's April 2021 MAR y for risperidone (used to treat three times daily with a ration time of 8:00am, 2:00pm vas not documented as /30/21 at 2:00pm or 8:00pm.				
		pharmacy on 07/01/21 at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		FCL017018	B. WING			2/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSOI NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 55	{C 342}			
	three times dailyThey would receive from the doctor and f. Review of Reside revealed: -There was an entry high cholesterol) 40 administration time -Atorvastatin 40mg administered on 04. Telephone interview facility's contracted 2:11pm revealed: -The pharmacy had 40mg at bedtime for	nt #3's April 2021 MAR y for atorvastatin (used to treat and daily with a scheduled of 8:00pm. was not documented as /30/21.; y with a Pharmacist at the pharmacy on 07/01/21 at I an order for atorvastatin r Resident #3. e medication orders by fax				
		dent #3 on 07/02/21 at 8:55am ook her medications daily.				
	revealed: -She did not know we medications in April -She thought she si JulyThe aspirin did not it was an over the content of the Attempted telephone.	gned off all medications for need to be on the MAR since ounter medication.				

Division of Health Service Regulation STATE FORM

6899 QLFL12 If continuation sheet 56 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING			R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
TAVI OR	FAMILY CARE HOME	1136 BEF	RTHA WILSO	N ROAD		
IAILON	TAMILI CARL HOME	BLANCH	, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
C 346	Continued From pa	ge 56	C 346			
C 346	10A NCAC 13G .10 Administration	004(n) Medication	C 346			
	(n) The facility shall administered in accomeasures that help and transmission of cross-contamination sanitary environment. This Rule is not me Based on observatifialled to ensure me accordance with infevidence by staff di	ons and interviews, the facility dications were administered in ection control measures as spensing oral medications into placing them in a medication				
	The findings are: Observation of the	morning medication pass on				
	07/01/21 from 9:05: -The Supervisor-in- preparing medication residentThe SIC did not sation starting the admit resident.	am -10:30am revealed: Charge (SIC) initiated ons for administration for a nitize or wash her hands prior nistration of medications for a				
	resident by punchin dose packs into her -The SIC placed the cup. -The SIC administe	8 oral medications for a g the medications from the bare, ungloved hand. e medications into a souffle red medications to a resident. of hand sanitizer with a pump				
	dispenser on the m Observation of ano					

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	FCL017018		B. WING		R 07/02/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	TAYLOR FAMILY CARE HOME #2 1136 BEI			N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 346	-The SIC initiated p administration for a -The SIC did not sa to starting the admi second residentThe SIC prepared second resident by from the dose pack handThe SIC placed the cupThe SIC administer residentThe SIC did not sa to, during, or after a to the second residentThere was a bottle dispenser on the m Interview with the S revealed: -The last infection of She washed her has 8:00am medication she was not aware.	reparing medications for second resident. nitize or wash her hands prior nistration of medications for a 9 oral medications for a punching the medications into her bare, ungloved a medications into a souffle red medications to a second nitize or wash her hands prior administering the medications ent. of hand sanitizer with a pump edication cabinet. IC on 07/02/21 at 11:00am control training was in 2019. ands before starting the	C 346			
C 375	into her hands. 10A NCAC 13G .10	09(a)(1) Pharmaceutical Care	C 375			
	(a) The facility shallicensed pharmacis registered nurse for pharmaceutical car residents or more fithe Department, basignificant medicatimonitoring visits or	109 Pharmaceutical Care II obtain the services of a t, prescribing practitioner or the provision of e at least quarterly for requently as determined by sed on the documentation of on problems identified during other investigations in which sidents may be at risk.				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 58 of 69

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ECI 047049			F 07/0	
		FCL017018			07/0	2/2021
NAME OF F				STATE, ZIP CODE		
TAYLOR FAMILY CARE HOME #2			THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 375	Pharmaceutical car prevention and resc problems which inc (1) an on-site medic which includes at let (A) the review of infrecord such as diag discharge summary orders, progress not medication administ current medication determine that medications, and identified and report prescribing practition (B) making recomminecessary, based of outcomes and ensurprescribing practition (C) documenting the review in the resides. This Rule is not medication that is not medication and the review in the resides. This Rule is not medication that is not medication and the review in the resides. This Rule is not medication that is not medication and the review in the resides. This Rule is not medication that is not medication and the review in the resides. This Rule is not medication that is not medication and the review in the resides. This Rule is not medication that is not medication and the review in the resides.	re involves the identification, plution of medication related ludes at least the following: cation review for each resident east the following: formation in the resident's gnoses, history and physical, y, vital signs, physician's ptes, laboratory values and tration records, including administration records, to lications are administered as ure that any undesired side ad actual medication reactions medication errors are ted to the appropriate oner; and, nendations for change, if on desired medication uring that the appropriate oner is so informed; and, he results of the medication int's record; Let as evidenced by: views and interviews, the ure quarterly pharmaceutical leted for 2 of 3 sampled 3).	C 375			
	Review of Resident	:#1's Resident Register				

6899

Division of Health Service Regulation STATE FORM

revealed Resident #1 was admitted to the facility

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.		R	
		FCL017018	B. WING			2/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	・サン	THA WILSO NC 27212	N ROAD		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
C 375	Continued From page 59		C 375			
	in August 2020 (there was no specific date documented).					
		t #2's medical record revealed nacy review available for				
		ne interview with the 7/02/21 at 12:14pm was				
	Refer to the telephor Pharmacist at the forms 07/01/21 at 3:47	acility's contracted pharmacy				
	Refer to the intervie on 07/02/01 at 9:20	ew with Supervisor-in-Charge lam.				
	2. Review of Resident #3's current FL2 dated 07/30/20 revealed diagnoses included schizophrenia, psychosis, tobacco disorder, schizoaffective disorder, bipolar type, hypertension, diabetes type 2, hyperlipidemia.					
		t #3's resident register nt was admitted to the facility				
		t #3's medical record on here were no pharmacy sion.				
		ne interview with the 7/02/21 at 12:14pm was				
		one interview with a acility's contracted pharmacy 'pm.				

6899

Division of Health Service Regulation
STATE FORM

QLFL12 If continuation sheet 60 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY MPLETED	
		FCL017018	B. WING		07/0	R 2/2021	
NAME OF F				STATE, ZIP CODE	1 0170		
TAYLOR FAMILY CARE HOME #2			THA WILSO NC 27212	N ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
C 375	Continued From pa	ge 60	C 375				
C 612	Refer to the interview with Supervisor-in-Charge (SIC) on 07/02/01 at 9:20am. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/01/21 at 3:47pm revealed: -When pharmacy reviews were completed they would sign and date the residents pharmacy review recordThe pharmacy did not keep a copy of pharmacy reviews, the facility was responsible for ensuring the documents were in the residents medical recordRecommendations would be documented on the pharmacy review record in each residents medical record. Interview with SIC on 07/02/01 at 9:20am revealed: -She knew pharmacy reviews were supposed to be completed quarterlyShe had to call the pharmacy to request the reviews be completedThe pharmacist had not been to the facility since July 2020 according to the SIC		C 612				
C 01 2	Control Program (to 10A NCAC 13G .17 PREVENTION AND (c) When a commu- been identified at the emerging infectious threat, the facility si the facility 's IPCP, procedures, and put	701 INFECTION D CONTROL PROGRAM unicable disease outbreak has ne facility or there is an s disease hall ensure implementation of related policies and ublished the CDC; however, if	COIZ				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 61 of 69

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING			R 02/2021
					1 0770	1212U2 I
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S THA WILSO	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	NC 27212	N KOAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 612	'	_	C 612			
	issued in writing by department, the spe	disease threat have been the NCDHHS or local health				
	interviews the facilit recommendations a for Disease Control when caring for 3 re	ons, record reviews and by failed to ensure and guidance by the Centers (CDC) were implemented esidents during the global D-19) pandemic as related to				
	The findings are:					
	Prevention (CDC) L Prevention and Cor Response to COVII 03/10/21 revealed: -This guidance app (HCP) while at work residents while they healthcare setting -Screen and Triage Healthcare Facility (COVID-19 -Establish a process	ers for Disease Control and Updated Healthcare Infection ntrol Recommendations in D-19 Vaccination dated lies to all healthcare personnel and all patients and are being cared for in a Everyone Entering a for Signs and Symptoms of s to ensure everyone e personnel, and visitors)				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 62 of 69

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING			R 02/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
TAYLOR	FAMILY CARE HOME	#2	RTHA WILSO NC 27212	N ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
C 612	entering the facility COVID-19Screening for feve be incorporated into admitted patients. Interview with three between 9:36am-10The Supervisor-intheir temperatures and taken their temperatures are symptoms of COVID Review of a resider June 2021 medicat (MAR) for a resider June 2021 medicat (MAR) for a resider are resident's tem 04/27/21-04/29/21The resident's tem 05/02/21-05/11/21, -There were no other interview with the S07/01/21 at 11:49ar -She was taking the every dayShe stopped taking after all the resident's temperat -She wrote the resident's temperat -She wrote the resident on outings shopping Attempted telephore	is assessed for symptoms of and symptoms should also daily assessments of all aresidents on 07/01/21 0:00am revealed: Charge (SIC) did not take daily. The last time the SIC had altures. The last time the SIC had altures altures alture was documented on 05/14/21, and 05/17/21. The last time the SIC had altures altures altures altures altures altures altures altures altures. The last time the SIC had	C 612				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 63 of 69

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL017018		B. WING		67/0	R 02/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
C 612	Continued From pa	ge 63	C 612			
	unsuccessful.					
{C 912}	, ,	eclaration of Residents' Rights	{C 912}			
	Every resident shall 2. To receive care a adequate, appropria	aration of Resident's Rights have the following rights: and services which are ate, and in compliance with state laws and rules and				
	interviews, the facili residents received of adequate, appropria relevant federal and regulations related	et as evidenced by: ons, record reviews, and ty failed to ensure the care and services that were ate, and in compliance with d state laws and rules and to medication administration, edication Aide training and				
	The findings are:					
	interviews, the facili implementation of p sampled residents (Resident #3) with o sugar (FSBS) check blood pressure check	ations, record reviews, and ty failed to ensure the physician's orders for 3 of 3 (Resident #1, #2, and rders for finger stick blood ks (Resident #1, #2, #3) and cks (#2). [Refer to Tag 0249 CAC 13G .0902 (C) (3-4) violation.)]				
	reviews, the facility medications as orderesidents (#1, #2 ar	ered for 3 of 3 sampled nd #3) related to an eation (#1), a medication used				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 64 of 69

	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		07/0	R 12/2021
					1 0770	12/2021
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S THA WILSO	STATE, ZIP CODE		
TAYLOR	FAMILY CARE HOME	#2	NC 27212	NROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 912}	Continued From pa	ge 64	{C 912}			
	0330 10A NCAC 13 Administration (Una 3. Based on intervie facility failed to ensu	d a sedative (#3). [Refer to Tag G .1004 (a) Medication abated Type B violation.)] ews and record reviews, the ure 1 of 1 staff (Staff A)				
	completed 5, 10, or medication aide trai medication clinical s prior to administerir [Refer to Tag 0935]	nistered medications had 15-hour mandated Ining and completed their skills competency validation ng medications (Staff A). Medication Aide Training and 31D 4.5B (Unabated Type B				
C 934	G.S.131D-4.5B (a) Requirements	ACH Infection Prevention	C 934			
	G.S. 131D-4.5B Add Prevention Require	ult Care Home Infection ments				
	Service Regulation annual in-service transmuration and practices for injectic during which bleeding glucose monitoring, successfully comple program shall received termined by the Econtinuing education home medication and services transmurates.	o12, the Division of Health shall develop a mandatory, aining program for adult care ides on infection control, safe ons and any other procedures ing typically occurs, and Each medication aide who etes the in-service training we partial credit, in an amount Department, toward the in requirements for adult care ides established by the ant to G.S. 131D-4.5				
	This Rule is not me Based on interview	et as evidenced by: and record review, the facility				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 65 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1101 1.111	or contraction	BEITH 10/11/01/11/01/BEIT	A. BUILDING:			
		FCL017018	B. WING		07/0	? 2/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TAYLOR FAMILY CARE HOME #2			THA WILSO NC 27212	N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 934	Continued From pa	nge 65	C 934			
	failed to ensure the state-mandated annual infection control training had been completed for 1 of 1 medication aide (Staff A).					
	The findings are:					
	Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -There was no documentation of the hire date for Staff A. -There was no documentation Staff A completed any state-mandated annual infection control training since 2018. Interview with Staff A on 07/02/21 at 11:37am revealed: -She had infection control training "year before last." -She went to the pharmacy once a year to complete infection control training in the past. -She had not been to the pharmacy for infection					
	-She had not called inquire about annual -She thought the pl	the COVID-19 pandemic. If the pharmacy in 2021 to all infection control training, narmacist was going to call her en the class was available.				
		ne interview with the 7/02/21 at 12:14pm was				
{C935}	G.S. § 131D-4.5B (Aides;Training and		{C935}			
		(b) Adult Care Home Fraining and Competency ments.				
	(b) Beginning Octo	ber 1, 2013, an adult care				

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 66 of 69

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING.		F	,
	FCL017018	B. WING			2/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
TAYLOR FAMILY CARE HOME #	! ?	THA WILSOI NC 27212	N ROAD		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
any unsupervised methat individual has premedication aide durin an adult care home of the following: (1) A five-hour training Department that incluin all of the following: a. The key principles administration. b. The federal Center Prevention guidelines applicable, safe inject procedures for monite bleeding occurs or the exists. (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days froindividual must have a. An additional 10-hode developed by the Deptraining and instruction 1. The key principles administration. 2. The federal Center Prevention guidelines applicable, safe inject procedures for monite bleeding occurs or the exists. b. An examination deby the Division of Head accordance with substitute is not met FOLLOW-UP TO TYPE.	om allowing staff to perform edication aide duties unless eviously worked as a genthe previous 24 months in or successfully completed all genthe program developed by the udes training and instruction of medication rs for Disease Control and so on infection control and, if tion practices and oring or testing in which the potential for bleeding aluation consistent with 10A de 10A NCAC 13G .0503. The date of hire, the completed the following: our training program partment that includes on in all of the following: of medication rs of Disease Control and so on infection control and, if tion practices and oring or testing in which the potential for bleeding eveloped and administered alth Service Regulation in section (c) of this section. as evidenced by:	{C935}			

Division of Health Service Regulation

STATE FORM 6899 QLFL12 If continuation sheet 67 of 69

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING			R 02/2021	
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
IAYLOR FAMILY CARE HOME #2			RTHA WILSOI , NC 27212	N ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
{C935}	Violation was not al Based on interview facility failed to ens sampled who admit completed 5, 10, or medication aide tra medication clinical prior to administerin Review of Staff A's, personnel record re-There was docume a 5-hour medication -There was docume a 5-hour medication -There was no doct an additional 10-ho -There was no doct the medication clinivalidation. Interview with Staff revealed: -She had a 5-hour in before she took the November 2018She did not know additional 10-hour in -No one observed in -She did not know additional to-medication administering medication on 07 unsuccessful.	bated. s and record reviews, the ure 1 of 1 staff (Staff A) inistered medications had 15-hour mandated ining and completed their skills competency validation or medications (Staff A). Supervisor-in-Charge (SIC), evealed: entation Staff A had completed in training class on 11/27/18. entation Staff A passed the ation examination on 12/20/18. umentation Staff A completed ur medication training class. umentation Staff A completed cal skills competency A on 07/02/21 at 11:37am medication training class is state medication exam in she needed to have an medication training class. The needed to have an medication training class. The needed a nurse to cation clinical skills ion form prior to her	{C935}				

6899

Division of Health Service Regulation STATE FORM

QLFL12 If continuation sheet 68 of 69

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					F	
		FCL017018	B. WING		07/0	2/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
TAYLOR	TAYLOR FAMILY CARE HOME #2 1136 BEANCH			N ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C935}	Continued From pa	ge 68	{C935}			
	Medication Adminis	tration.				
	Refer to Tag C342 Medication Adminis	10A NCAC 13G .1004(j) tration.				
	Refer to Tag C346 Medication Adminis	10A NCAC 13G .1004(n) tration				
	(Staff A) who admir competency validat 15-hour mandated medications. The famedication errors, for medication admir to administer medicinfection control medetrimental to the house the residents and control medication.	ensure 1 of 1 sampled staff histered medications were ed and completed a total of training prior to administering histration records and failure to ensure the accuracy histration records and failure eation in accordance with heasures. These failures were ealth, safety, and welfare of constitutes an Unabated Type B				
		TE FOR THE TYPE B NOT EXCEED AUGUST 16,				