STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments The Adult Care Licensure Section conducted a Follow-Up Survey on 07/01/21-07/02/21.	{C 000}		
C 133	10A NCAC 13G. 0403(c) Qualifications of Medication Staff 10A NCAC 13G. 0403 Qualifications of Medication Staff (c) Medication aides and staff who directly supervise the administration of medications, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 medication aides sampled (A) completed six hours of continuing education annually related to medication administration. The findings are: Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -There was documentation Staff A had completed a 5-hour medication training class on 11/27/18. -There was documentation Staff A passed the state written medication examination on 12/20/18. -There was no documentation Staff A completed any continuing education units (CEU) related to medication administration since 2018. Interview with Staff A on 07/02/21 at 11:37am revealed: -She had not had six hours of CEU related to medication administration annually.	C 133		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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C 133	Continued From page 1 -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 133		
{C 145}	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 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: 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 indicating a HCPR check was completed. Interview with Staff A on 07/02/21 at 11:37am revealed: -She thought her family member had checked her HCPR. -She thought the results of the HCPR were in her	{C 145}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 145}	Continued From page 2 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 145}		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) had completed competency validation for licensed health professional support (LHPS) task related to checking finger stick blood sugar. The findings are: Review of the Staff A's, Supervisor-in-Charge (SIC) personnel record revealed:	C 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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C 171	Continued From page 3 -There was no documentation of a hire date for Staff A. -There was no documentation of Staff A's LHPS tasks competency validation checklist. Review of three resident's records revealed there were orders to check FSBS twice daily for one resident, daily for another resident and weekly for another resident. 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 her. -There were no other LHPS tasks for any of the current residents. -The nurse did not complete a LHPS tasks competency validation checklist because she did not have the form with her. Observation of Resident #1's FSBS on 07/01/21 at 11:48am revealed: -The SIC did not wash her hands before applying her gloves. -The SIC asked for directions on how to turn the glucometer on. -The SIC performed a finger stick on Resident #1. -The SIC attempted to add blood to the glucometer strip before placing the strip in machine, after realizing she needed to place the strip in the glucometer she then attempted to place blood on the strip instead of allowing strip to absorb blood from the end of strip, -The SIC used Resident #1's glucometer to check the resident's FSBS. -The FSBS reading was 140. Attempted telephone interview with the facility's contracted LHPS nurse 07/01/21 at 12:02pm was unsuccessful.	C 171		

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C 171	Continued From page 4 Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.	C 171		
{C 230}	10A NCAC 13G .0801(a) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register. 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: Review of Resident #2's current FL-2 dated 08/05/20 revealed diagnoses included schizophrenia, bipolar disorder, adjustment disorder, and altered mental status. Review of Resident #2's record revealed there was no Resident Register available for review. Interview with the Supervisor-in-Charge (SIC) on 07/01/21 at 9:48am revealed Resident #2 was admitted to the facility on 05/11/21. Interview with Resident #2 on 07/01/21 at 9:36am revealed she had been at the facility for "over a month" but she was not sure of her date of admission.	{C 230}		

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{C 230}	Continued From page 5 Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 9:05am revealed: -She had not completed a resident register on Resident #2 because she did not know who the resident's guardian was. -She was responsible for completing the Resident Register on new admissions. -She admitted the residents to the facility. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.	{C 230}		
{C 231}	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource.	{C 231}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 231}	Continued From page 6 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that a care plan and assessment were completed within 30-days of admission for 1 of 3 sampled residents (#2). 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. Interview with the Supervisor-in-Charge (SIC) on 07/01/21 at 9:48am revealed Resident #2 was admitted to the facility on 05/11/21. Review of Resident #2's record revealed there was no care plan available for review. Interview with the Supervisor-in-Charge on Supervisor-in-Charge (SIC) on 07/02/21 at 9:05am revealed: -Resident #2 had not been to see a primary care provider (PCP). -She was responsible for completing the resident care plans on new admissions. -She admitted the residents to the facility. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.	{C 231}		
{C 246}	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care	{C 246}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 246}	Continued From page 7 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure referrals were completed for 2 of 3 sampled residents related to a resident who had a referral for an eye exam (#3) and a diabetic resident who had a referral to a podiatrist (#1). The findings are: 1. Review of Resident #1's current FL-2 dated 07/07/20 revealed diagnoses included diabetes, Alzheimer's dementia, 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 trimmed. -A diagnosis of toenail deformity was documented. -A referral to a podiatrist was scheduled. Interview with Resident #1 on 07/01/21 at 11:26am revealed: -She had not been to a podiatrist. -She wanted to go to a podiatrist. -She did not know why she had not been to a podiatrist. -She thought her PCP had to make an appointment. Observation of Resident #3's toenails on 07/01/21 at 11:26am revealed: -The first toenail on her left foot was completely missing.	{C 246}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 246}	Continued From page 8 -The toenails on the rest of her toes on the left foot extended over the end of her toes and were jagged. -The first toenail on her right foot was over ¾ missing. -The toenails on all of her toes on the right foot extended over the end of the toe by ¼ inch and one was beginning to curl under. -Both of her feet were covered in a build-up of dead and peeling skin. Telephone interview with Resident #3's PCP's referral coordinator on 07/01/21 at 2:21pm revealed a referral was made for Resident #3 to see a podiatrist on 06/01/21. Telephone interview with the appointment coordinator at the podiatrist office on 07/01/21 at 2:46pm revealed: -A referral was received for Resident #1 on 06/01/21. -She had attempted to contact the resident to schedule an appointment. -She had left multiple messages at the telephone number provided. -She verified the telephone number provided was the facility's telephone number. -No one had returned her telephone call. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 11:22am revealed: -She had received a voicemail from the podiatry office. -She did not return the call to the podiatry office. -She saw the telephone area code and thought the podiatry office was too far away. -She had not followed up with Resident #1's PCP to request a different referral. -She was not aware the podiatrist's office that had called was less than 20 minutes away from the	{C 246}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 246}	Continued From page 9 facility. Attempted telephone interviews with Resident #1's PCP on 07/01/21 at 4:17pm unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 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. Review of Resident #3's physician's order dated 03/26/21 revealed an order to schedule Resident #3 for a diabetic eye exam (once per year). Interview with Resident #3 on 07/01/21 at 10:30am revealed: -She had her eyes checked last year. -She did not recall the date of her last exam. -The doctor wanted her to have her eyes checked every year because of her diabetes. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 11:00am revealed: -She had not scheduled Resident #3's eye exam. -She did not know when Resident #3 was last seen by an eye doctor. -She would call the eye doctor to schedule the appointment. -She had forgotten to schedule the eye appointment that was ordered on 03/26/21. -She told Resident #3 two weeks ago that she needed to schedule her eye appointment. Telephone interview with a nurse at Resident #3's Primary Care Provider's (PCP) office on 07/06/21	{C 246}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 246}	Continued From page 10 at 1:32pm revealed: -Resident #3 was seen on 06/25/21 by the PCP. -Resident #3 was expected to have annual eye exams because of her diagnoses of diabetes. 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 246}		
{C 249}	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 3 of 3 sampled residents (Resident #1, #2, and Resident #3) with orders for finger stick blood sugar (FSBS) checks (Resident #1, #2, #3) and blood pressure checks (#2).	{C 249}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 249}	Continued From page 11 The findings are: 1. Review of Resident #2's current FL-2 dated 08/05/20 revealed diagnoses included schizophrenia, bipolar disorder, adjustment disorder, and altered mental status. a. Review of Resident #2's current FL-2 dated 08/05/20 revealed an order to check finger stick blood sugar (FSBS) twice daily. Interview with the Supervisor-in-Charge (SIC) on 07/01/21 at 9:48am revealed Resident #2 was admitted to the facility on 05/11/21. 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 MAR for June 2021 revealed: -There was no entry to check Resident #2's FSBS twice daily. -There was no documentation Resident #2's FSBS was checked twice daily. Resident #2 did not have a May 2021 MAR available to be reviewed. Interview with Resident #2 on 07/01/21 at 9:36am revealed: -She had been at the facility for "over a month" but was not sure of her date of admission. -She had not had her FSBS checked since she had been admitted to the facility. -She did not know how often her FSBS were ordered to be checked. -Her FSBS was checked at her previous facility,	{C 249}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 249}	Continued From page 12 but she did not recall how often. Interview with the SIC on 07/02/21 at 11:02am revealed: -She did not know Resident #2 was supposed to have twice daily FSBS. -She did not see the order for twicedaily FSBS 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. -Resident #2 did not have a glucometer to check her FSBS. -She had not obtained a glucometer for Resident #2 because she did not know the resident had orders for FSBS. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/01/21 at 1:20pm revealed: -The pharmacy entered orders on the MARs for the facility. -Resident #2's FL-2 was not sent to the pharmacy. -There was no order on file for Resident #2's twice daily FSBS. Telephone interview with Resident #2's primary care provider (PCP) on 07/01/21 at 3:56pm revealed: -He had completed Resident #2's FL-2 when she was under his care at the previous facility. -Resident #2 needed to have her FSBS checked twice daily as ordered. -Resident #2's FSBS checks were ordered because he was concerned Resident #2's diabetes mellitus was not controlled because Resident #2 had a history of non-compliance with her diet and often refused medications. -The FSBS would help him monitor Resident #2's	{C 249}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 249}	Continued From page 13 diabetes. -If Resident #2's FSBS were not checked, the resident could be experiencing hyperglycemia which could lead to long-term organ damage, including liver, lungs, eyes, "pretty much all organs" could be impacted. -No one had contacted him to discuss Resident #2's orders. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. b. Review of Resident #2's current FL-2 dated 08/05/20 revealed an order to check the resident's blood pressure (BP) on the 1st and 15th of the month. 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 medication administration record (MAR) for June 2021 revealed: -There was no entry to check Resident #2's BP on the 1st and 15th of the month. -There was no documentation Resident #2's BP had been checked. Interview with Resident #2 on 07/01/21 at 9:36am revealed: -She had not had her BP checked since she had been admitted to the facility. -She did not know how often her BP was ordered to be checked. -Her BP was checked at her previous facility, but she did not recall how often.	{C 249}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 249}	Continued From page 14 Interview with the SIC on 07/02/21 at 11:02am revealed: -She did not know Resident #2 was supposed to have her BP checked twice a month, on the 1st and 15th. -She did not see the 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. Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/01/21 at 1:20pm revealed: -The pharmacy entered orders on the MARs for the facility. -Resident #2's FL-2 was not sent to the pharmacy. -There was no order on file for Resident #2's twice monthly blood pressure checks. Observation of Resident #2's BP on 07/01/21 at 10:57am revealed: -The SIC used a digital BP machine to check the resident's BP. -The BP reading was 74/56. -A second BP was obtained and the reading was 100/60. -A third BP was obtained and the reading was 99/68. Telephone interview with Resident #2's primary care provider (PCP) on 07/01/21 at 3:56pm revealed: -He had completed Resident #2's FL-2 when she was under his care at the previous facility. -Resident #2 took medication for high blood pressure. -He was concerned Resident #2's blood pressure was not checked as ordered because he would	{C 249}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 249}	Continued From page 15	{C 249}		

not know if the resident's blood pressure was maintained at a therapeutic range or not if the blood pressure was not checked.
-No one had contacted him to discuss Resident #2's orders.

Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.

2. Review of Resident #1's current FL-2 dated 07/07/20 revealed:
-Diagnoses included Alzheimer's dementia, anxiety, diabetes, and hypertension.
-There was an order to check Resident #1's finger stick blood sugar (FSBS) once a week.

Review of Resident #1's medication administration records (MAR) for April 2021, May 2021, and June 2021 revealed:
-There was no entry to check Resident #1's FSBS.
-There was no documentation Resident #1's FSBS was checked.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 07/01/21 at 4:34pm revealed an order was received from Resident #1's primary care provider (PCP) on 10/16/20 for glucometer test strips and check FSBS daily.

Interview with Resident #1 on 07/01/21 at 8:55am revealed she has not had her FSBS checked since she moved into the facility "almost a year ago."

Interview with the Supervisor-in-Charge (SIC) on 07/01/21 at 10:33am revealed:
-She had not checked Resident #1's FSBS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 249}	Continued From page 16 because Resident #1's glucometer was not working. -Resident #1's FSBS was checked by the SIC's family member, who was a nurse, using a glucometer the family member had brought with her to the facility sometime in May 2021. -She thought Resident #1's FSBS was 102 when it was checked, but she did not document the reading on Resident #1's MAR. -She had not attempted to obtain a new glucometer for Resident #1. Observation of Resident #1's glucometer on 07/01/21 at 11:48am revealed: -The glucometer bag was not labeled and the glucometer was not labeled. -The date and time had not been set in the glucometer. -There was no FSBS results in the glucometer's history. Observation of Resident #1's FSBS on 07/01/21 at 11:48am revealed: -The SIC used Resident #1's glucometer to check the resident's FSBS. -The FSBS reading was 140. Attempted telephone interviews with Resident #1's PCP on 07/01/21 at 4:17pm unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 3. 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.	{C 249}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 249}	Continued From page 17 Review of Resident #3's physician's order dated 09/18/20 revealed: -There was an order to discontinue the resident's finger stick blood sugar (FSBS) checks four times daily. -There was an order for the resident to have FSBS checked every morning. Review of Resident #3's physician's order dated 03/26/21 revealed there was an order to check fasting FSBS every morning and record on the medication administration record (MAR). Review of Resident #3's MARs for April 2021, May 2021, and June 2021 revealed: -There was no entry to check the resident's FSBS daily. -There was an entry to check the resident's FSBS four times a day. -There was no documentation that the resident's FSBS was checked. Interview with Resident #3 on 07/01/21 at 10:30am revealed: -She did not want her blood sugar checked. -She could not afford the glucometer, lancets and strips. Interview with the Supervisor-in-Charge (SIC) on 07/01/21 at 10:10am revealed: -She had spoken to the pharmacist last week about the glucometer and strips. -Resident #3 did not want her blood sugar checked. Interview with the Nurse at Resident #3's Primary Care Provider's (PCP) office on 07/06/21 at 1:32pm revealed an order was sent to another pharmacy for a glucometer.	{C 249}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 249}	Continued From page 18 Interview with Resident #3 on 07/02/21 at 9:45am revealed: -She would like to have a glucometer if she did not have to pay for it. -She would check her FSBS if she did not have to pay for the supplies. Interview with a technician at another pharmacy on 07/07/21 at 1:17pm revealed: -The pharmacy received an electronic script for a glucometer in April 2021. -The pharmacy attempted to reach the resident without success. -The pharmacy no longer provided service to this resident. -The pharmacy did not recall notifying the PCP that the order was not filled. 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. _____ The facility failed to implement orders for FSBS for three residents who had physician's orders to take FSBS daily (#1, #3) and twice daily FSBS (#2). The facility's failure to check the FSBS placed the diabetic residents at risk for side effects of hyperglycemia and hypoglycemia. The facility failed to implement an order for twice a month blood pressure checks for a resident who took medication to lower her blood pressure (#2) and the resident's blood pressure had not been checked since admission. The facility's failure to check the resident's blood pressure prohibited the primary care provider from knowing if the resident's blood pressure was maintained at a	{C 249}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 249}	Continued From page 19 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. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 16, 2021.	{C 249}		
{C 254}	10A NCAC 13G .0903(c) Licensed Health 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 (4) documenting the activities in Subparagraphs	{C 254}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 254}	Continued From page 20 (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a quarterly Licensed Health Professional Support (LHPS) evaluation had been completed by a licensed health professional for 3 of 3 sampled residents (#1, #2, and #3) with an LHPS task of finger stick blood sugars (FSBS). The findings are: 1. 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. Interview with the Supervisor-in-Charge (SIC) on 07/01/21 at 9:48am revealed Resident #2 was admitted to the facility on 05/11/21. Review of Resident #2's medication administration record (MAR) for June 2021 revealed: -There was no entry to check Resident #2's FSBS twice daily. -There was no documentation Resident #2's FSBS was checked twice daily. Review of Resident #2's medical record revealed there was no Licensed Health Professional Support (LHPS) evaluation available for review. Interview with the SIC on 07/02/21 at 11:02am revealed: -Her family member was a nurse and was the	{C 254}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 254}	Continued From page 21 LHPS nurse. -Resident #2 was not a resident at the facility when the nurse was last at the facility. -She did not know Resident #2 was supposed to have twice daily FSBS so she had not requested the nurse to do an LHPS evaluation. -She had contacted the LHPS nurse on 07/01/21 and requested an evaluation for Resident #2. Attempted telephone interview with the facility's contracted LHPS nurse 07/01/21 at 12:02pm was unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 2. Review of Resident #1's current FL-2 dated 07/07/20 revealed: -Diagnoses included Alzheimer's dementia, anxiety, diabetes, and hypertension. -There was an order to check Resident #3's finger stick blood sugar (FSBS) once a week. Review of Resident #1's MARs for February 2021, March 2021, and April 2021 revealed: -There was no entry to check Resident #1's FSBS daily. -There was no documentation Resident #1's FSBS was checked. Review of Resident #1's medical record revealed there was no Licensed Health Professional Support (LHPS) evaluation record available for review. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 11:02am revealed: -Resident #1 had an LHPS task of FSBS. -The LHPS nurse had completed the LHPS	{C 254}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 254}	Continued From page 22	{C 254}		

evaluation on Resident #1 "about a week after the last survey."
-She did not know if an LHPS form was completed.
-She would call the LHPS nurse.

Resident #1's LHPS evaluation form was requested on 07/02/21 at 11:02am was not provided prior to exit on 07/02/21.

Attempted telephone interview with the facility's contracted LHPS nurse 07/01/21 at 12:02pm was unsuccessful.

Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.

3. 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.

Review of Resident #3's physician's order dated 09/18/20 revealed:
-There was an order to discontinue finger stick blood sugar (FSBS) checks four times daily.
-There was an order for FSBS check every morning.

Review of Resident #3's physician's order dated 03/26/21 revealed there was an order to check fasting FSBS (before eating or drinking) every morning and record on the medication administration record (MAR).

Review of Resident #3's MARs for April 2021, May 2021, and June 2021 revealed:
-There was no entry to check Resident #3's

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 254}	Continued From page 23 FSBS daily. -There was no documentation Resident #3's FSBS was checked. Review of Resident #3's medical record revealed there was no Licensed Health Professional Support (LHPS) evaluation available for review. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 11:00am revealed: -Resident #3 did not have any LHPS tasks. -Resident #3 did not have a glucometer to check her blood sugars. -She did not ask the LHPS nurse to assess Resident #3 because she did not receive FSBS. Attempted telephone interview with the facility's contracted LHPS nurse 07/01/21 at 12:02pm was unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.	{C 254}		
{C 270}	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic menus for food service guidance for 3	{C 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 270}	Continued From page 24 of 3 sampled residents (#1, #2, #3) with physician orders for a no concentrated sweets (NCS) diet (#1); a low concentrated sweet (LCS) diet (#2), and a low carb diet (#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 cereal. -Each 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 cup. -One cup contained 12 grams of sugar. -One 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 follow. -There was not diet list for the staff to follow. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 11:03am revealed: -She did not have a diet list. -She had a regular menu and one for residents with diabetes. -The menu's had been packed up because she was preparing to paint in the facility. -She had the menu's one day last week. -She did not need the menu to prepare food because she fixed what the residents were served normally. -She did not measure the amount of cereal provided to the residents. 1. Review of Resident #2's current FL-2 dated	{C 270}		

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{C 270}	Continued From page 25 08/05/20 revealed: -Diagnoses included schizophrenia, bipolar disorder, adjustment disorder, and altered mental status. -There was an order for a low concentrated sweets (LCS) diet. Interview with the Supervisor-in-Charge on 07/02/21 at 11:02am revealed: -Resident #2 was not on a special diet. -She did not receive an FL-2 on Resident #2 until a week after the resident was admitted. -She probably looked at the diet order but forgot. -Resident #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 followed. -Resident #2 should not have been served two cups of cereal on a LCS diet. -If Resident #2 was not served a LCS diet she could become hyperglycemic (elevated blood sugar). Attempted interview with Resident #2 on 07/02/21 at 9:50am was unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 2. Review of Resident #1's current FL-2 dated 07/07/20 revealed: -Diagnoses included diabetes, Alzheimer's dementia, anxiety, and hypertension. -There was an order for a no concentrated sweets (NCS) diet.	{C 270}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 270}	Continued From page 26 Interview with Resident #1 on 07/02/21 at 9:28am revealed: -She was not on a special diet. -She did not know what a NCS diet was. -She ate whatever was provided for her to eat. -She ate a lot of cereal. Interview with the Supervisor-in-Charge on Supervisor-in-Charge (SIC) on 07/02/21 at 11:03am revealed: -Resident #1 was not on a special diet. -She could not read what was listed on Resident #1's FL-2 for diet. -She did not know what a NCS diet was and had not asked for clarification. Attempted telephone interview with Resident #1's PCP on 07/01/21 at 4:17pm unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 3. 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. Review of Resident #3's signed physician's order dated 06/25/21 revealed an order for a low carbohydrate diet (avoid rice, potatoes and white bread). Observation of the breakfast meal served on 07/01/21 at 8:55am revealed: -Resident #3 was served a bowl of cereal; the bowl contained at least two cups of cereal with milk. -Resident #3 was served an 8-ounce glass of	{C 270}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 270}	Continued From page 27	{C 270}		

orange juice and an 8-ounce glass of water.
-Resident #3 consumed 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 toast.
-Resident #3 was served an 8-ounce glass of orange juice and 8-ounce glass of water.
-Resident #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 bread.
-She had a blood sugar greater than 300 when her FSBS was checked at the PCP's office on 06/25/21.
-She could go into a diabetic coma if her blood sugar continued to be high.

Interview with Resident #3 on 07/02/21 at 9:00am revealed:
-The resident went to a fast food restaurant for lunch on 07/01/21.
-The resident had a chicken sandwich for lunch.
-The resident had pizza for dinner from a fast food restaurant on 07/01/21.

Interview with the Supervisor-in-Charge on 07/01/21 at 10:10am revealed:
-Resident #3 was not to eat rice, potatoes or white bread.
-Resident #3 could go into a diabetic coma.

Interview with a nurse at Resident #3's PCP's office on 07/06/21 at 1:32 pm revealed;
-Resident #3 needed to follow her diet as ordered due to her diabetes.
-Resident #3's A1C (The hemoglobin A1C test tells you your average level of blood sugar over the past 2 to 3 months. According to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 270}	Continued From page 28 American Diabetic a HbgA1C value less than 7.0 is a goal for diabetic residents with the normal range for HbA1C being 4 to 5.9) was 7.9 on 06/25/21. 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 270}		
C 320	10A NCAC 13G .1002 (f) Medication Orders 10A NCAC 13G .1002 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 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 2 of 2 sampled residents (#1and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/07/20 revealed: -Diagnoses included Alzheimer's dementia, anxiety, diabetes, and hypertension. -There was an order for Metoprolol tartrate 25mg	C 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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C 320	Continued From page 29 (used to treat hypertension) take one tablet daily. -There was an order for Risperdal 1mg (antipsychotic) take one tablet twice daily. -There was an order for Vitamin D 1000 units (nutritional supplement) daily. -There was an order for Venlafaxine 100mg (antidepressant) take ½ tablet twice daily. -There was an order for Aspirin 81mg (blood thinner) take one tablet daily. -There was an order for Atorvastatin 80mg (used to treat high cholesterol) take one tablet daily. -There was an order for Buspirone 5mg (used to treat anxiety) take one tablet three times daily. -There was an order for Calcium antacid tablet 500mg (used to relieve heartburn) take one tablet twice daily. -There was an order for Fenofibrate 145mg (used to lower cholesterol) take one tablet daily. -There was an order for Gabapentin 300mg (used to treat nerve pain) take one tablet at bedtime. -There was an order for Lamotrigine 200mg (used to treat bipolar disorder) take one tablet at bedtime. -There was an order for Lorazepam 0.5mg (used to treat anxiety) take one tablet at bedtime and as needed. -There was an order for Losartan potassium 50mg (used to treat high blood pressure) take one tablet daily. -There was an order for Namenda 10mg (used to slow the progression of dementia) take one tablet twice daily. Review of Resident #1's Resident Register revealed she was admitted to the facility August 2020 (there was no date listed). Review of Resident #1's medical record revealed there were no six-month signed physician's orders for medications.	C 320		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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C 320	Continued From page 30 Refer to the interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 9:20am. 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. Review of Resident #3's discharge summary dated 07/31/20 revealed: -There was an order for aspirin (used as a blood thinner) 81 mg daily. -There was an order for diphenhydramine (used to treat involuntary movements and muscle stiffness) 50mg three times a day. -There was an order for glipizide (used to treat diabetes) 10mg daily before breakfast. -There was an order for iloperidine (an anti-psychotic medication) 10mg three times a day. -There was an order for lisinopril (used to treat high blood pressure) 20mg daily. -There was an order for magnesium oxide (used as a supplement) 400mg daily. -There was an order for metformin (used to treat diabetes) 1000mg two times a day. -There was an order for simvastatin (used to lower cholesterol) 40mg every evening. -There was an order for temazepam (used as a sedative to treat insomnia) 30mg every night. Review of Resident #3's resident register revealed the resident was admitted to the facility on 7/31/20. Review of Resident #3's medical record revealed there were no six months physician order	C 320		

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C 320	Continued From page 31 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 320		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION	{C 330}		

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{C 330}	Continued From page 32 Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2 and #3) related to an antipsychotic medication (#1), a medication used to treat the side effects of antipsychotic medication (#2) and 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. Review of Resident #3's physician's order dated 09/18/20 revealed an order to decrease Temazepam (a sedative used to treat insomnia) to 15mg at bedtime. Review of Resident #3's April 2021 medication administration record (MAR) revealed: -There was an electronic entry for Temazepam 30mg daily with a scheduled administration time of 8:00pm. -There was a handwritten entry to change Temazepam to 15mg daily with a scheduled administration time of 8:00pm. -There was a hand-written entry for Temazepam changed to 15mg at bedtime dated 09/18/20. -There was no documentation Temazepam 15mg was administered. -There was no documentation Temazepam 30mg was administered at 8:00pm. Review of Resident #3's May 2021 MAR	{C 330}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 330}	Continued From page 33 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 8:00pm. 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. 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 dispensed on 08/03/20. -Temazepam 30mg was dispensed on 08/27/20 for 30-tablets. -There were no refills left on Resident #3's Temazepam prescription. -The pharmacy did not receive the physician's order as per the review dated 09/18/20 or a prescription for Temazepam 15mg. -No one from the facility called to inquire about the Temazepam 15mg. Interview with the Supervisor-in-Charge on	{C 330}		

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{C 330}	Continued From page 34 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 telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 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). 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 MAR for June 2021 revealed: -There was an entry for Austedo 12mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Austedo 12mg was documented as administered from 06/01/21-06/30/21 at 8:00am and 8:00pm. Review of Resident #2's MAR for July 2021 revealed:	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 330}	Continued From page 35 -There was an entry for Austedo 12mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Austedo 12mg was documented as administered on 07/01/21 at 8:00am and 8:00pm. Observation of Resident #2's medication release form dated 05/11/21 revealed Resident #2 had 32 tablets of Austedo 12mg transferred from her previous facility to this facility. Review of Resident #2's medications on hand on 07/01/21 at 11:48am revealed: -There was a prescription bottle of Austedo 12mg dispensed on 04/16/21 for 60 tablets. -There were 11 tablets available to be administered. -There was no other Austedo available to be administered. 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 tablets. -There were 11 tablets available to be 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	{C 330}		

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{C 330}	Continued From page 36 provided to the facility, a total of 60-tablets were dispensed in a punch card. -On 06/25/21, the SIC requested refills on Resident #2's medications, including the Austedo 12mg. -A 4-day supply of Austedo 12mg was dispensed in a punch card on 06/25/21. Observation of Resident #2 on 07/01/21 at 11:00am revealed: -The SIC was checking Resident #2's blood pressure. -Resident #2 was having an involuntary jerking in her arm. -The SIC told Resident #2 to "quit shaking." Interview with Resident #2 on 07/02/21 at 9:50am revealed: -Without opening her eyes, she stated, "I am depressed, and I am not talking." -She would not respond to any other questions. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 11:33am revealed: -She administered and documented Resident #2's Austedo 12mg last night, 07/01/21. -She thought she administered the Austedo 12mg out of the prescription bottle. -She did not know why the count was the same on 07/01/21 and 07/02/21. -She may have only administered Austedo once on 07/02/21 because she thought the medication was once a day. -When she read the pharmacy label on the Austedo prescription bottle, she saw "take one tablet" she did not see the twice a day. Attempted telephone interview with Resident #2's mental health provider on 07/01/21 at 4:58pm was unsuccessful.	{C 330}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 330}	Continued From page 37 Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 3. Review of Resident #1's current FL-2 dated 07/07/20 revealed diagnoses included diabetes, Alzheimer's dementia, anxiety and hypertension. Review of Resident #1's physician's order dated 07/07/20 revealed an order for Buspirone HCL (antipsychotic medication used to treat anxiety) 5mg three times daily. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Buspirone 5mg three times daily with a scheduled administration time of 8:00am, 12:00pm and 8:00pm. -There was documentation Buspirone 5mg was administered at 8:00am, 12:00pm, and 8:00pm on 05/01/21-05/10/21. -Buspirone 5mg was not documented as administered at 12:00pm from 05/11/21-05/26/21. -Buspirone 5mg was documented as administered at 8:00am and 8:00pm on 05/11/21-05/26/21 and at 8:00am on 05/27/21. -Buspirone 5mg was not documented as administered on 05/27/21 at 12:00pm and 8:00pm. -Buspirone 5mg was not documented as administered on 05/28/21-05/31/21. -Sixty-three tablets of Buspirone 5mg were documented as administered; thirty nine of the sixty-three tablets were documented as administered between 05/09/21-05/27/21. Review of Resident #1's June 2021 MAR revealed: -There was an entry for Buspirone 5mg three	{C 330}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 330}	Continued From page 38 times daily with a scheduled administration time of 8:00am, 12:00pm and 8:00pm. -There was documentation Buspirone 5mg was administered at 8:00am, 12:00pm, and 8:00pm on 06/01/21-06/30/21. -Ninety tablets of Buspirone 5mg were documented as administered. Observation of Resident #1's medication on hand on 07/01/21 at 11:48am revealed: -There was a punch card labeled Buspirone HCL 5mg take one tablet three times daily dispensed on 05/08/21 with 12 of 90 tablets available to be administered. -There were three punch cards labeled Buspirone HCL 5mg take one tablet three times daily dispensed on 06/21/21 with 90 of 90 tablets available to be administered. Telephone interview with a pharmacy technician on 07/01/21 at 2:58pm revealed: -Resident #1's Buspirone 5mg was a cycle filled medication and was dispensed every 30-days. -Resident #1's Buspirone 5mg was filled on 05/08/21 for 90 tablets and 06/21/21 for 90 tablets and was on schedule to be filled on 07/20/21 for 90 tablets. -Resident #1's Buspirone 5mg dispensed on 05/08/21 for 90 tablets was most likely not picked up on 05/08/21 and therefore the scheduled dispensing for 06/08/21 was bumped forward until 06/21/21. -She did not think there should be "that many" tablets of Buspirone on hand. Based on observation of medications on hand, dispensing records, and record review for Resident #1 from 05/09/21-07/01/21, 129 tablets of Buspirone were documented as administered; there should have been 51 of 180 Buspirone	{C 330}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 330}	Continued From page 39 tablets remaining; 102 tablets were left on hand. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 11:33am revealed: -Resident #1's Buspirone was administered three times a day. -Resident #1's 12:00pm may not have been administered at 12:00pm but was administered by 2:00pm. -She did not know why there were more medications on hand than should have been if the medication was administered three times a day. -Resident #1 had not ran out of her medications, she may not have documented administering Resident #1's Buspirone but the medication was administered. Interview with Resident #1 on 07/01/21 at 10:06am revealed: -She took medication twice a day, at breakfast and dinner. -She did not take medications during the day, only in the morning and in the evening. -She did not remember if she had missed getting her medications at the end of May 2021. Interview with Resident #1 on 07/02/21 at 9:28am revealed: -She felt anxious. -She got a "nervous feeling" and had to get up and walk around. -She did not remember when she last felt this way, but it had been "this week." -Sometimes she felt this way every day. -She had not been sleeping well. -She had a headache every morning when she woke up. -She had not told anyone about her headaches because the SIC had so much "on her."	{C 330}		

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 330}	Continued From page 40 Attempted telephone interviews with Resident #1's PCP on 07/01/21 at 4:17pm unsuccessful. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. _____ The facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, and #3) who was not administered medications as ordered including medication to treat insomnia #3; and an anti-psychotic medication that was ordered to be administered three times a day and was only administered twice daily for a resident who had experienced feeling anxious (#1); and a medication used to treat the side effects of anti-psychotic medication including involuntary movement and was noted to be experiencing involuntary movement on 07/01/21 (#2). The failure of the facility to administer medications as ordered was detrimental to the health, safety, and welfare 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. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 16, 2021.	{C 330}		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 342}	Continued From page 41 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. 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 Austedo 12mg take one tablet twice a day. (Austedo is used to decrease involuntary movements of the face, tongue, or other body parts). -There was an order for Clozapine 10mg take one tablet at bedtime. (Clozapine is an	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 342}	Continued From page 42	{C 342}		

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 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 one page available to be reviewed.
-There was no entry for Clozapine 10mg take one tablet at bedtime.
-There was no entry for Lithium Carb 300mg take one tablet at bedtime.

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{C 342}	Continued From page 43 -There was no entry for Oxybutynin 5mg take two tablets daily. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 10:32am revealed: -She had not noticed there was a page missing from Resident #2's July 2021 MAR. -She administered Resident #2's bedtime medication last night, 07/01/21. -She did not document administering Resident #2's May 2021 medications because the resident did not have a MAR for May 2021. -She administered the medications that were transferred with the resident at admission (05/11/21) using the punch cards the medication was dispensed in. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 2. Review of Resident #1's current FL-2 dated 07/07/20 revealed diagnoses included diabetes, Alzheimer's dementia, anxiety, and hypertension. a. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Metoprolol tartrate 25mg (used to treat hypertension) take one tablet daily. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Metoprolol Tartrate 25mg twice daily with a scheduled administration time of 8:00am and 5:00pm. -There was no documentation Metoprolol Tartrate was administered on 05/27/21 at 5:00pm. -There was no documentation Metoprolol Tartrate was administered on 05/28/21-05/31/21.	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 44 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 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. b. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Risperidone 1mg (antipsychotic) take one tablet twice daily. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Risperidone 1mg twice daily with a scheduled administration time of 8:00am and 5:00pm. -There was no documentation Risperidone was administered on 05/27/21 at 5:00pm. -There was no documentation Risperidone 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 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. c. Review of Resident #1's physician's orders	{C 342}		

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{C 342}	Continued From page 45 dated 07/07/20 revealed there was an order for Vitamin D 1000 units (nutritional supplement) daily. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Vitamin D3 1000 units once daily with a scheduled administration time of 8:00am. -There was no documentation Vitamin D3 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 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. d. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Acidophilus (probiotic used to prevent yeast infections) once daily Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Acidophilus once daily with a scheduled administration time of 8:00am. -There was no documentation Acidophilus 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	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 46	{C 342}		

administered 05/27/21-05/21/21.
-She administered the medication, she "just missed" documenting the medication.

Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.

e. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Aspirin 81mg (used to prevent strokes) once daily

Review of Resident #1's May 2021 medication administration record (MAR) revealed:
-There was an entry for Aspirin 81mg once daily with a scheduled administration time of 8:00am.
-There was no documentation Aspirin 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 05/27/21-05/21/21.
-She administered the medication, she "just missed" documenting the medication.

Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.

f. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Atorvastatin 80mg (used to treat high cholesterol) take one tablet daily.

Review of Resident #1's May 2021 medication administration record (MAR) revealed:
-There was an entry for Atorvastatin 80mg once daily with a scheduled administration time of

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	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 47 8:00pm. -There was no documentation Atorvastatin was administered on 05/27/21-05/31/21. 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 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. g. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Loratadine 10mg (used to treat allergies) once daily. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Loratadine 10mg once daily with a scheduled administration time of 8:00am. -There was no documentation Loratadine 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 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{C 342}	Continued From page 48 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 8:00am. -There 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 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. i. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Losartan potassium 50mg take one tablet daily. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Losartan Potassium 50mg once daily with a scheduled administration time of 8:00am. -There was no documentation Losartan Potassium was administered on 05/28/21-05/31/21. Interview with the Supervisor-in-Charge (SIC) on	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 49 07/02/21 at 10:32am revealed: -She did not know why she had not documented on Resident #1's MAR for medications administered 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. j. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Buspirone 5mg (used to treat anxiety) take one tablet three times daily. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Buspirone 5mg three times daily with a scheduled administration time of 8:00am, 12:00pm and 5:00pm. -There was no documentation Buspirone was administered on 05/28/21-05/31/21 at 8:00am, 12:00pm and 5:00pm. -There was no documentation Buspirone was administered on 05/11/21-05/27/21 at 12:00pm. 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 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. -She did not know why she did not document administering Resident #2's 12:00pm dosage of Buspirone, she administered the medication. Interview with the Supervisor-in-Charge (SIC) on 07/02/21 at 10:32am revealed:	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 50 -She did not know why she had not documented on Resident #1's MAR for medications administered 05/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. k. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Gabapentin 300mg (used to treat nerve pain) take one tablet at bedtime. Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Gabapentin three times daily with a scheduled administration time of 8:00am, 12:00pm and 5:00pm. -There was no documentation Gabapentin was administered on 05/27/21-05/31/21. 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 o5/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. l. Review of Resident #1's physician's orders dated 07/07/20 revealed there was an order for Lamotrigine 200mg (used to treat bipolar disorder) take one tablet at bedtime.	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 51 Review of Resident #1's May 2021 medication administration record (MAR) revealed: -There was an entry for Lamotrigine 200mg once daily with a scheduled administration time of 8:00pm. -There was no documentation Lamotrigine was administered on 05/27/21-05/31/21. 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 o5/27/21-05/21/21. -She administered the medication, she "just missed" documenting the medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. 3. 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. a. Review of Resident #3's physician's order dated 09/18/20 revealed an order to decrease Temazepam (a sedative used to treat insomnia) to 15mg at bedtime. Review of Resident #3's April 2021 medication administration record (MAR) revealed: -There was an electronic entry for Temazepam 30mg daily with a scheduled administration time of 8:00pm. -There was a handwritten entry to change Temazepam to 15mg daily with a scheduled administration time of 8:00pm. -There was a hand-written entry for Temazepam	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 52 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 8:00pm. -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 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 dispensed on 08/03/20. -Temazepam 30mg was dispensed on 08/27/20 for 30-tablets. -There were no refills left on Resident #3's Temazepam prescription.	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

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{C 342}	Continued From page 53 -The pharmacy did not receive the physician's order as per the review dated 09/18/20 or a prescription for Temazepam 15mg. -No one from the facility called to inquire about the Temazepam 15mg. Interview with the Supervisor-in-Charge on 07/02/21 at 9:10am revealed she did not know Resident #3's Temazepam 15mg was not in multi-dose packet of night medications. b. Review of Resident #3's FL-2 dated 07/30/20 revealed there was an order for metformin (used to treat diabetes) 1000mg twice daily. Review of Resident #3's April 2021 MAR revealed there was an entry for metformin 500mg, two tablets twice a day, with a scheduled administration time of 8:00am and 8:00pm; metformin was not documented as administered on 4/30/21 at 8:00pm. Review of Resident #3's July 2021 MAR revealed there was an entry for metformin 500mg, two tablets twice a day, with a scheduled administration time of 8:00am and 8:00pm; metformin was not documented as administered on 07/01/21 at 8:00pm. c. Review of Resident #3's record revealed a hand written, signed physician's order for aspirin (used as a blood thinner) 81mg daily dated 03/26/21. Review of Resident #3's May 2021, June 2021 and July 2021 MARs revealed there was no entry for aspirin 81mg daily as ordered on 03/26/21. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/01/21 at	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 342}	Continued From page 54 2:11pm revealed: -The pharmacy had not received an order for aspirin 81mg daily for Resident #3. -They would receive medication orders by fax from the doctor and 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 #3. -They would receive medication orders by fax from the doctor and the facility. e. Review of Resident #3's April 2021 MAR revealed: -There was an entry for risperidone (used to treat schizophrenia) 3mg three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm. -Risperidone 3mg was not documented as administered on 04/30/21 at 2:00pm or 8:00pm. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/01/21 at	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ B. WING _____	R 07/02/2021

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{C 342}	Continued From page 55 2:11pm revealed: -The pharmacy had an order for risperidone 3 mg three times daily. -They would receive medication orders by fax from the doctor and the facility. f. Review of Resident #3's April 2021 MAR revealed: -There was an entry for atorvastatin (used to treat high cholesterol) 40mg daily with a scheduled administration time of 8:00pm. -Atorvastatin 40mg was not documented as administered on 04/30/21.; 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 atorvastatin 40mg at bedtime for Resident #3. -They would receive medication orders by fax from the doctor and the facility. Interview with Resident #3 on 07/02/21 at 8:55am revealed that she took her medications daily. Interview with the SIC on 07/02/21 at 10:30am revealed: -She did not know why she had not signed off on medications in April. -She thought she signed off all medications for July. -The aspirin did not need to be on the MAR since it was an over the counter medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.	{C 342}		

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C 346	Continued From page 56	C 346		
C 346	10A NCAC 13G .1004(n) Medication Administration 10A NCAC 13G .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were administered in accordance with infection control measures as evidence by staff dispensing oral medications into her bare hand, then placing them in a medication cup for 2 of 2 residents. The findings are: Observation of the morning medication pass on 07/01/21 from 9:05am -10:30am revealed: -The Supervisor-in-Charge (SIC) initiated preparing medications for administration for a resident. -The SIC did not sanitize or wash her hands prior to starting the administration of medications for a resident. -The SIC prepared 8 oral medications for a resident by punching the medications from the dose packs into her bare, ungloved hand. -The SIC placed the medications into a souffle cup. -The SIC administered medications to a resident. -There was a bottle of hand sanitizer with a pump dispenser on the medication cabinet. Observation of another morning medication pass on 07/01/21 from 9:05am - 10:30am revealed:	C 346		

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C 346	Continued From page 57 -The SIC initiated preparing medications for administration for a second resident. -The SIC did not sanitize or wash her hands prior to starting the administration of medications for a second resident. -The SIC prepared 9 oral medications for a second resident by punching the medications from the dose packs into her bare, ungloved hand. -The SIC placed the medications into a souffle cup. -The SIC administered medications to a second resident. -The SIC did not sanitize or wash her hands prior to, during, or after administering the medications to the second resident. -There was a bottle of hand sanitizer with a pump dispenser on the medication cabinet. Interview with the SIC on 07/02/21 at 11:00am revealed: -The last infection control training was in 2019. -She washed her hands before starting the 8:00am medication pass. -She was not aware that she could not pop pills into her hands.	C 346		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk.	C 375		

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C 375	Continued From page 58 Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmaceutical reviews were completed for 2 of 3 sampled residents (#1 and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/07/20 revealed diagnoses included Alzheimer's dementia, anxiety, diabetes, and hypertension. Review of Resident #1's Resident Register revealed Resident #1 was admitted to the facility	C 375		

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C 375	Continued From page 59 in August 2020 (there was no specific date documented). Review of Resident #2's medical record revealed there was no pharmacy review available for review. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. Refer to the telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/01/21 at 3:47pm. Refer to the interview with Supervisor-in-Charge on 07/02/01 at 9:20am. 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. Review of Resident #3's resident register revealed the resident was admitted to the facility on 7/31/21. Review of Resident #3's medical record on 07/01/21 revealed there were no pharmacy review since admission. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. Refer to the telephone interview with a Pharmacist at the facility's contracted pharmacy on 07/01/21 at 3:47pm.	C 375		

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C 375	Continued From page 60 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 record. -The pharmacy did not keep a copy of pharmacy reviews, the facility was responsible for ensuring the documents were in the residents medical record. -Recommendations 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 quarterly. -She had to call the pharmacy to request the reviews be completed. -The pharmacist had not been to the facility since July 2020 according to the SIC	C 375		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the	C 612		

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C 612	Continued From page 61 communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) were implemented when caring for 3 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of residents. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination dated 03/10/21 revealed: -This guidance applies to all healthcare personnel (HCP) while at work and all patients and residents while they are being cared for in a healthcare setting -Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19 -Establish a process to ensure everyone (patients, healthcare personnel, and visitors)	C 612		

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C 612	Continued From page 62 entering the facility is assessed for symptoms of COVID-19. -Screening for fever and symptoms should also be incorporated into daily assessments of all admitted patients. Interview with three residents on 07/01/21 between 9:36am-10:00am revealed: -The Supervisor-in-Charge (SIC) did not take their temperatures daily. -They did not recall the last time the SIC had taken their temperatures. -No one asked screening questions about symptoms of COVID-19. Review of a resident's April 2021, May 2021 and June 2021 medication administration records (MAR) for a resident revealed: -The resident's temperature was documented on 04/ 27/21-04/29/21. -The resident's temperature was documented on 05/02/21-05/11/21, 05/14/21, and 05/17/21. -There were no other temperatures documented. Interview with the Supervisor-in-Charge (SIC) on 07/01/21 at 11:49am revealed: -She was taking the residents' temperatures every day. -She stopped taking the residents' temperatures after all the residents had been vaccinated. -She did not recall when she had last checked the resident's temperatures. -She wrote the residents' temperatures on the back of the medication administration record (MAR). -She and the residents did leave the facility to go on outings shopping and out to eat. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was	C 612		

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C 612	Continued From page 63 unsuccessful.	C 612		
{C 912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to medication administration, health care, and Medication Aide training and competency. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure the implementation of physician's orders for 3 of 3 sampled residents (Resident #1, #2, and Resident #3) with orders for finger stick blood sugar (FSBS) checks (Resident #1, #2, #3) and blood pressure checks (#2). [Refer to Tag 0249 Health Care 10A NCAC 13G .0902 (C) (3-4) (Unabated Type B violation.)] 2. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2 and #3) related to an antipsychotic medication (#1), a medication used to treat the side effects of antipsychotic	{C 912}		

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{C 912}	Continued From page 64 medication (#2) and a sedative (#3). [Refer to Tag 0330 10A NCAC 13G .1004 (a) Medication Administration (Unabated Type B violation.)] 3. Based on interviews and record reviews, the facility failed to ensure 1 of 1 staff (Staff A) sampled who administered medications had completed 5, 10, or 15-hour mandated medication aide training and completed their medication clinical skills competency validation prior to administering medications (Staff A). [Refer to Tag 0935 Medication Aide Training and Competency G.S. 131D 4.5B (Unabated Type B violation.)]	{C 912}		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on interview and record review, the facility	C 934		

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C 934	Continued From page 65 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 control training since the COVID-19 pandemic. -She had not called the pharmacy in 2021 to inquire about annual infection control training. -She thought the pharmacist was going to call her family member when the class was available. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful.	C 934		
{C935}	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care	{C935}		

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{C935}	Continued From page 66 home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B	{C935}		

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{C935}	Continued From page 67 Violation was not abated. Based on interviews and record reviews, the facility failed to ensure 1 of 1 staff (Staff A) sampled who administered medications had completed 5, 10, or 15-hour mandated medication aide training and completed their medication clinical skills competency validation prior to administering medications (Staff A). Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: -There was documentation Staff A had completed a 5-hour medication training class on 11/27/18. -There was documentation Staff A passed the state written medication examination on 12/20/18. -There was no documentation Staff A completed an additional 10-hour medication training class. -There was no documentation Staff A completed the medication clinical skills competency validation. Interview with Staff A on 07/02/21 at 11:37am revealed: -She had a 5-hour medication training class before she took the state medication exam in November 2018. -She did not know she needed to have an additional 10-hour medication training class. -No one observed her administer medication. -She did not know she needed a nurse to complete the medication clinical skills competency validation form prior to her administering medication. Attempted telephone interview with the Administrator on 07/02/21 at 12:14pm was unsuccessful. Refer to Tag C330 10A NCAC 13G .1004(a)	{C935}		

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TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD BLANCH, NC 27212

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C935}	Continued From page 68 Medication Administration. Refer to Tag C342 10A NCAC 13G .1004(j) Medication Administration. Refer to Tag C346 10A NCAC 13G .1004(n) Medication Administration The facility failed to ensure 1 of 1 sampled staff (Staff A) who administered medications were competency validated and completed a total of 15-hour mandated training prior to administering medications. The facility failure resulted in medication errors, failure to ensure the accuracy of medication administration records and failure to administer medication in accordance with infection control measures. These failures were detrimental to the health, safety, and welfare 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. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 16, 2021.	{C935}		