PRINTED: 10/04/2018

| Division o | of Health Service Regu | lation | | | FORM | 1 APPROVED |
|--------------------------|--|--|----------------------------------|---|-------------------------------|--------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | FCL061008 | B. WING | | 09/1 | ₹ 3/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | ADDRESS, CITY, STAT | FE, ZIP CODE | | |
| B & L FAN | IILY CARE HOME | | IE CREEK ROAD SVILLE, NC 2870 | 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| C 000 | Initial Comments | | C 000 | | | |
| | annual and follow-up 2018, with an exit cor September 13, 2018. | sure Section conducted an survey on September 12, nference via telephone on | | | | |
| C 327 | 10A NCAC 13G .1003 | 3 (e) Medication Lable | C 327 | | | |
| | 10A NCAC 13G .1003 | 3 Medication Labels | | | | |
| | | I not be transferred from her except when prepared | | | | |
| | reviews, the facility fa medications in origina sampled residents (R | ns, interviews, and record iled to keep dispensed al packaging for 1 of 3 | | | | |

-There was an order for omeprazole 40mg take 1 capsule by mouth twice daily (used to treat acid reflux).

08/28/18 revealed:

prescription bottles.

hemiplegia, and hemiparesis.

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

original dispensed packaging to previously used

Review of Resident #1's current FL2 dated 08/22/18 revealed diagnoses included traumatic brain injury, dysphagia, opioid dependence,

Review of Resident #1's Resident Registar revealed an admission date of 08/24/18.

Review of Resident #1's medication list included on an electronically signed doctor's note dated

TITLE (X6) DATE

| Division of Health Service Regulation | | | | | | |
|---------------------------------------|---|---|---------------------|--|-------------------------------|--|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | FCL061008 | B. WING | | R 09/13/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE ZIP CODE | · | |
| TWAME OF T | KOVIDEIK OK OOI I EIEK | | E CREEK ROAD | 12,211 0002 | | |
| B & L FAN | IILY CARE HOME | | VILLE, NC 2870 | 5 | | |
| 0/4) ID | SLIMMADV ST | ATEMENT OF DEFICIENCIES | ı, | PROVIDER'S PLAN OF CORRECTIO | N (VE) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE | |
| C 327 | Continued From page | e 1 | C 327 | | | |
| | -There was an order of take 1 tablet by mouth (used to treat pain)There was an order of half tablet by mouth of blood pressure)There was an order of 20mEq take 1 tablet by as a supplement)There was an order of take 1 capsule by modepression)There was an order of take 1 capsule by modepression)There was an order of tablet by mouth twice seizures)There was an order of tablet by mouth evenerve pain)There was an order of take 1 tablet by mouth (used to treat thyroid)There was an order of tablet by mouth 3 time anxiety)There was an order of tablet by mouth twice. Review of Resident #Administration Record | for hydromorphone 2mg in every 8 hours as needed for metoprolol 25mg take ince daily (used to treat for potassium chloride by mouth 4 times daily (used for venlafaxine ER 75mg inth once daily (used to treat for venlafaxine ER 150mg inth once daily (used to treat for Vimpat 100mg take 1 daily (used to treat for gabapentin 400mg take 2 very 6 hours (used to treat for levothyroxine 25mcg in once daily in the morning disease). for lorazepam 1mg take 1 les daily (used to treat for furosemide 40mg take 1 daily (used to treat fluid). 1's August 2018 Medication d (MAR) revealed | | | | |
| | medications had beer administered from 08. | /24/18 to 08/31/18. | | | | |
| | Review of Resident # | 1's September 2018 MAR | | | | |

Division of Health Service Regulation

revealed medications had been documented as administered from 09/01/18 to 09/12/18.

Observation of Resident #1's medication on hand

STATE FORM 6899 HOFE11 If continuation sheet 2 of 11

Division of Health Service Regulation

| Bivioloti of Flouriti col vice i togal | lation | | |
|---|--|---|-------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | (X3) DATE SURVEY COMPLETED |
| | FCL061008 | B. WING | R 09/13/2018 |
| NAME OF PROVIDER OR SUPPLIER | STREET ADD | RESS CITY STATE ZIP CODE | |

842 CANE CREEK ROAD

| B & L FAMILY CARE HOME | | 842 CANE CREEK ROAD | | | | |
|--------------------------|---|---|--------------------|--|--------------------------|--|
| DULIA | MET GARE HOME | BAKERSVILLE, N | NC 28705 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCI (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM | Y FULL PF | ID REFIX FAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| C 327 | Continued From page 2 | C 3 | 27 | | | |
| | on 09/12/18 revealed: -There were 11 medications that had been transferred from their original packagingThe following medications were available admnistered to Resident #1, omeprazole hydromorphone 2mg, metoprolol 25mg, potassium chloride 20mEq, venlafazine E 75mg, venlafaxine ER 150mg, Vimpat 10 gabapentine 400mg, levothyroxine 25mcg lorazepam 1mg, and furosemide 40mgEach prescription label showed a dispenthat was prior to Resident #1's admission facilityPrescription bottles did not matchBottles were orange or brown with white, or blue lidsPrescription labels were taped to each bendeications were correctly labeledThe remaining medications were in their container from the dispensing pharmacy. Interview with Resident #1 on 09/12/18 at revealed she had received all her medicationes she had moved into the facility. Interview with the Administrator on 09/12/9:50am revealed: -Resident #1 had brought a lot of medicate the facility on admissionEach medication was originally packed individually in a medication cardShe did not have enough room in the medication to lock up all the medicationsShe had popped out all the tablets from emedication card and put them in "old president with the she had at the facilityShe had removed the label from the medicationShe thought it would be okay to transfer. | e to be 40mg, IR 0mg, g, se date to orange ottle. original a 4:45pm tions at at cions to edication each ccription dication for each | 27 | | | |
| Division of Hea | alth Service Regulation | | | | | |

STATE FORM 6899 HOFE11 If continuation sheet 3 of 11

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|----------------------------|--|------|--------------------------|
| | | FCL061008 | FCL061008 B. WING | | 09/1 | ₹ 3/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET ADD | RESS, CITY, STA | TE, ZIP CODE | | |
| B & L FAN | IILY CARE HOME | | CREEK ROAD LLE, NC 2870 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETE DATE |
| C 327 | Continued From page | 3 | C 327 | | | |
| | bottles to allow the mestorageShe did not think the pharmacy would reparate the pharmacy would reparate the resident because repackaged with the vestorage. | vith a pharmacist from the narmacy on 09/12/18 at | | | | |
| C 367 | Telephone interview with a nurse from Resident #1's Primary Care Physician's (PCP) office on 09/12/18 at 4:03pm revealed: -There was a risk of putting the wrong medication in a bottle with the wrong label if medications were repackaged from their original packagingIt was best practice to obtain new prescriptions from the pharmacy and to not use the medications that had been repackaged. | | C 367 | | | |
| 3 307 | 10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. | | 330. | | | |

Division of Health Service Regulation

This Rule is not met as evidenced by:

STATE FORM 6899 HOFE11 If continuation sheet 4 of 11

Division of Health Service Regulation

| Division | of Health Service Regu | liation | | | | |
|-----------|------------------------|--|------------------|--|------------------|------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | | | | 1 _ | _ |
| | | | D WING | | F | |
| | | FCL061008 | B. WING | | 09/1 | 13/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET AF | DRESS, CITY, STA | TE ZIP CODE | | |
| | | | | | | |
| B & L FAN | IILY CARE HOME | | CREEK ROAD | | | |
| | | BAKERS | VILLE, NC 2870 | 05 | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | , | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE | | COMPLETE DATE |
| TAG | REGULATORY ORY | EGC IDENTIF TING INFORMATION) | TAG | DEFICIENCY) | NAIL | 5,112 |
| | | | | | | |
| C 367 | Continued From page | e 4 | C 367 | | | |
| | Daned on observation | as interviews and record | | | | |
| | | ns, interviews, and record | | | | |
| | | ailed to assure a record of | | | | |
| | | s was available for 2 of 2 | | | | |
| | • | tesident #1 and #4) related | | | | |
| | | chedule II medicatoin used | | | | |
| | | am (schedule IV medication | | | | |
| | used to treat anxiety) | | | | | |
| | medication used to tr | , . | | | | |
| | | le IV medication used to | | | | |
| | treat seizure disorder | ·). | | | | |
| | | | | | | |
| | | t #1's current FL2 dated | | | | |
| | | agnoses included traumatic | | | | |
| | | ia, opioid dependence, | | | | |
| | hemiplegia, and hem | iparesis. | | | | |
| | | | | | | |
| | Review of Resident # | 1's Resident Register | | | | |
| | revealed an admissio | on date of 08/24/18. | | | | |
| | | | | | | |
| | a. Review of Residen | t #1's medication list on an | | | | |
| | electronically signed | doctor's note dated 08/28/18 | | | | |
| | revealed an order for | hydromorphone 2mg take 1 | | | | |
| | tablet every 8 hours a | as needed. | | | | |
| | | | | | | |
| | Review of Resident # | 1's August 2018 Medication | | | | |
| | Administration Recor | d (MAR) revealed: | | | | |
| | -There was a comput | er generated entry for | | | | |
| | hydromorphone 2mg | take 1 tablet every 8 hours | | | | |
| | to be administered at | 8:00am, 1:00pm, and | | | | |
| | 8:00pm. | | | | | |
| | -Hydromorphone 2mg | g had been documented as | | | | |
| | | s from 08/24/18 to 08/31/18. | | | | |
| | | | | | | |
| | Review of Resident # | 1's September 2018 MAR | | | | |
| | revealed: | · | | | | |
| | | er generated entry for | | | | |
| | | take 1 tablet every 8 hours | | | | |
| | | 8:00am, 1:00pm, and | | | | |
| | 8:00pm. | , a.i.a | | | | |
| | | g had been documented as | | | | |
| | , | J 200 4004 | 1 | 1 | | 1 |

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STATE FORM 6899 HOFE11 If continuation sheet 5 of 11

PRINTED: 10/04/2018

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CO A. BUILDING: | | (X3) DATE S COMPLE | |
|--------------------------|---|---|----------------------------------|---|-----------------------|--------------------------|
| | | | | | R | |
| | | FCL061008 | B. WING | | 09/1 | 3/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE, | , ZIP CODE | | |
| R&IFAN | MILY CARE HOME | 842 CAN | IE CREEK ROAD | | | |
| | | BAKERS | SVILLE, NC 28705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETE DATE |
| C 367 | Continued From page | e 5 | C 367 | | | |
| | administered 34 times | s from 09/01/18 to 09/12/18. | | | | |
| | hand on 09/12/18 at an arthere was 11 tablets available to be adminusurable showed 90 tables Resident #1 prior to a Review of Resident # | s of hydromorphone 2mg histered. helets had been dispensed to hadmission on 08/20/18. helet's controlled substance ho count sheet was available | | | | |
| | Interview with Reside revealed: -She had received all had moved into the fa-She had not ran out dose of medication. Telephone interview v | ent #1 on 09/12/18 at 4:45pm her medications since she | | | | |

Interview with the Administrator on 09/12/18 at 3:44pm revealed:

2:52pm revealed that the pharmacy had not dispensed any hydromorphone 2mg to Resident

-She did not know how many hydromorphone 2mg tablets Resident #1 had brought to the facility on admission.

-Resident #1 had asked for a dose of hydromorphone 2mg 3 times daily since admission.

-She did not consider the hydromorphone 2mg as an as needed medication for Resident #1.

-She had forgotten that she needed to keep an inventory record for each controlled substances. -She had not had a resident on a controlled

substance in a "long time."

#1.

Division of Health Service Regulation

STATE FORM 6899 HOFE11 If continuation sheet 6 of 11

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | |
|--|--|---|--|---|-----------------|
| | FCL061008 B. WING | | B. WING | | R 09/13/2018 |
| | ROVIDER OR SUPPLIER | 842 CANE | DRESS, CITY, STA | | • |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETE |
| C 367 | Continued From page | e 6 | C 367 | | |
| | electronically signed or revealed an order for tablet by mouth every Review of Resident # revealed: -There was a comput lorazepam 1mg take administered at 8:00a-Lorazepam 1mg had administered 22 times. Review of Resident # revealed: -There was a comput lorazepam 1mg take administered at 8:00a-Lorazepam 1mg take administered at 8:00a-Lorazepam 1mg had administered 34 times. Observation of Resid 09/12/18 at 12:24pm-There was 12 whole of lorazepam 1mg av-Label showed 90 tab Resident #1 prior to a Review of Resident # count sheet revealed available for lorazepam Interview with Reside revealed: -She had received all had moved into the face | er generated entry for 1 tablet every 8 hours to be am, 1:00pm, and 8:00pm. I been documented as is from 08/24/18 to 08/31/18. It's September 2018 MAR er generated entry for 1 tablet every 8 hours to be am, 1:00pm, and 8:00pm. I been documented as is from 09/01/18 to 09/12/18. I been documented as is from 09/01/18 to 09/12/18. I been documented as is from 09/01/18 to 09/12/18. I sent #1's medication on revealed: tablets and 3 partial tablets ailable to be administered. I been dispensed to admission on 08/20/18. It's controlled substance no count sheet was am 1mg. Int #1 on 09/12/18 at 4:45pm her medications since she | | | |

Division of Health Service Regulation

STATE FORM 6899 HOFE11 If continuation sheet 7 of 11

| Division o | <u>of Health Service Regu</u> | lation | | | | |
|------------|-------------------------------|--|-------------------|---|------------------|--|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: _ | | COMPLETED | |
| | | | | | R | |
| | | FCL061008 | B. WING | | 09/13/2018 | |
| | | | | | 1 00/10/2010 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STA | TE, ZIP CODE | | |
| R & I FAM | B & L FAMILY CARE HOME | | E CREEK ROAD | | | |
| BAKERSV | | VILLE, NC 2870 | 5 | | | |
| (X4) ID | | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CORRECTIO | | |
| PREFIX | | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI | | |
| TAG | REGULATORT ORT | EGG IDENTIF TING INFORMATION) | TAG | DEFICIENCY) | WAIL SALE | |
| | | | | | | |
| C 367 | Continued From page | e 7 | C 367 | | | |
| | Telephone interview v | with a pharmacist from the | | | | |
| | | harmacy on 09/12/18 at | | | | |
| | - | the pharmacy had not | | | | |
| | • | pam 1mg to Resident #1. | | | | |
| | , , | . 3 | | | | |
| | Interview with the Adr | ministrator on 09/12/18 at | | | | |
| | 3:44pm revealed: | | | | | |
| | -She did not know ho | w many lorazepam 1mg | | | | |
| | tablets Resident #1 h | ad brought to the facility on | | | | |
| | admission. | | | | | |
| | | at she needed to keep an | | | | |
| | • | ach controlled substances. | | | | |
| | | esident on a controlled | | | | |
| | substance in a "long t | time." | | | | |
| | a Daview of Decides | t #1's medication list on an | | | | |
| | | doctor's note dated 08/28/18 | | | | |
| | | Vimpat 100mg take 1 tablet | | | | |
| | by mouth twice daily. | | | | | |
| | by mouth twice daily. | | | | | |
| | Review of Resident # | 1's August 2018 MAR | | | | |
| | revealed: | 1 0 7 tagaot 20 10 10 11 11 t | | | | |
| | -There was a comput | er generated entry for | | | | |
| | | tablet by mouth twice daily | | | | |
| | to be administered at | | | | | |
| | -Vimpat 100mg had b | peen documented as | | | | |
| | administered 15 times | s from 08/24/18 to 08/31/18. | | | | |
| | | | | | | |
| | | 1's September 2018 MAR | | | | |
| | revealed: | | | | | |
| | | er generated entry for | | | | |
| | - | tablet by mouth twice daily | | | | |
| | | 8:00am and 8:00pm. | | | | |
| | -Vimpat 100mg had b | | | | | |
| | auministered 23 times | s from 09/01/18 to 09/12/18. | | | | |
| | Observation of Pools | ent #1's medication on | | | | |
| | 09/12/18 at 12:24pm | | | | | |
| | | revealed. s of Vimpat 100mg available | | | | |
| | - ITICIE Was 23 lablets | or virripat rouning available | - 1 | | | |

Division of Health Service Regulation

to be administered.

STATE FORM 6899 HOFE11 If continuation sheet 8 of 11

Division of Health Service Regulation

| DIVISION | of Health Service Regu | | | | (X3) DATE SURVEY | |
|-------------------|---|--|-------------------------------|--|------------------|--|
| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE Co | (X2) MULTIPLE CONSTRUCTION | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING: | | COMPLETED | |
| | | | | | R | |
| | | FCL061008 | B. WING | | 09/13/2018 | |
| NAME OF P | ROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, STATE | ZIP CODE | | |
| NAME OF I | NOVIDEN ON 3011 EIEN | | | , ZII GODE | | |
| B & L FAI | MILY CARE HOME | | E CREEK ROAD SVILLE, NC 28705 | | | |
| | | | SVILLE, NC 20705 | | | |
| (X4) ID PREFIX | | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL | () | |
| TAG | | LSC IDENTIFYING INFORMATION) | TAG | CROSS-REFERENCED TO THE APPRO | l l | |
| | | | | DEFICIENCY) | | |
| C 367 | Continued From page | e 8 | C 367 | | | |
| | | | | | | |
| | | plets had been dispensed to | | | | |
| | Resident #1 prior to a | admission on 08/13/18. | | | | |
| | Paview of Pasident # | 1's controlled substance | | | | |
| | count sheet revealed | | | | | |
| | available for Vimpat | | | | | |
| | available for virripat | | | | | |
| | Interview with Reside | ent #1 on 09/12/18 at 4:45pm | | | | |
| | revealed: | | | | | |
| | -She had received all her medications since she | | | | | |
| | had moved into the fa | • | | | | |
| | | of medication or missed a | | | | |
| | dose of medication. | | | | | |
| | Tolonhono intonvious | with a pharmacist from the | | | | |
| | I - | harmacy on 09/12/18 at | | | | |
| | | the pharmacy had not | | | | |
| | dispensed Vimpat 10 | | | | | |
| | | 3 | | | | |
| | Interview with the Adı | ministrator on 09/12/18 at | | | | |
| | 3:44pm revealed: | | | | | |
| | | w many Vimpat 100mg | | | | |
| | | ad brought to the facility on | | | | |
| | admission. | | | | | |
| | | mpat was considered a | | | | |
| | controlled substance. | at she needed to keep an | | | | |
| | | each controlled substances. | | | | |
| | | esident on a controlled | | | | |
| | substance in a "long" | | | | | |
| | | | | | | |
| | 2. Review of Residen | t #4's current FL2 dated | | | | |
| | 03/01/18 revealed: | | | | | |
| | -Diagnoses included | seizure disorder and | | | | |
| | memory loss. | | | | | |
| | | for clonazepam 0.5mg 3 | | | | |
| | times daily (used to to | reat seizure disorder). | | | | |

Division of Health Service Regulation

Review of Resident #4's Resident Register revealed an admission date of 12/15/17.

STATE FORM 6899 HOFE11 If continuation sheet 9 of 11

Division of Health Service Regulation

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|---|-------------------------------|--|
| | | | 50.25.140 | | R | |
| | | FCL061008 | B. WING | | 09/13/2018 | |
| NAME OF PI | ROVIDER OR SUPPLIER | STREET AL | DDRESS, CITY, STA | TE, ZIP CODE | | |
| B&LFAN | IILY CARE HOME | 842 CAN | E CREEK ROAD | | | |
| 2 4 2 1 7 11 | | | VILLE, NC 2870 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETE | |
| C 367 | Continued From page | 9 | C 367 | | | |
| | doctor's notes dated of for clonazepam 0.5m morning, ½ tablet at I bedtime for 2 weeks, the morning, ½ tablet bedtime. Review of Resident # revealed: -There was an entry f ½ tablet twice daily at at 8pmClonazepam had be administered 90 times. Review of Resident # revealed: -There was an entry f ½ tablet twice daily at at 8pmClonazepam had be administered 34 times at 8pmClonazepam had be administered 34 times at 8am. Observation of Resid on 09/12/18 at 4:00prThere were 88 tablet available to be administered 90 table Resident #4 on 09/08. Review of Resident # count sheet revealed available for clonazep | unch, and 1 tablet at then decrease to ½ tablet in a tal lunch, and 1 tablet at 4's August 2018 MAR for clonazepam 0.5mg, take to 8am and 2pm, and 1 tablet en documented as so from 08/01/18 to 08/31/18. for clonazepam 0.5mg, take to 8am and 2pm, and 1 tablet en documented as so from 09/01/18 to 09/12/18 for clonazepam 0.5mg, take to 8am and 2pm, and 1 tablet en documented as so from 09/01/18 to 09/12/18 for the first medication on hand more ealed: for clonazepam 0.5mg, take to 9/12/18 for clonazepam 0.5mg, take to 9/12/18 | | | | |
| | Telephone interview v 09/13/18 at 3:55pm re | with the pharmacy on evealed clonazepam 0.5mg, | | | | |

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quantity 90 had been dispensed on 09/8/18.

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE C | | (X3) DATE COMF | SURVEY PLETED | |
|---|---|--|-----------------------------------|--|---------------------------------|--------------------------|
| | | | | | | R |
| | | FCL061008 | B. WING | | 09 | /13/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | ADDRESS, CITY, STATE | , ZIP CODE | | |
| B & L FAN | IILY CARE HOME | | NE CREEK ROAD SVILLE, NC 28705 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| C 367 | Continued From page | e 10 | C 367 | | | |
| | 4:00pm revealed: -Resident #4 was on substance)She had forgotten the inventory record for one of the control | clonazepam (a controlled at she needed to keep an clonazepam. interview with Resident #4's as unsuccessful on 09/12/18. | | | | |

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