Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081052	A. BUILDING: ______ B. WING ______	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 3	**149 REID STREET FOREST CITY, NC 28043**

(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 annual and follow-up survey on October 10, 2019.	C 000		
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: Based on observations, interviews, and record reviews, the facility failed to implement a physician's orders for 1 of 3 sampled residents (Resident #2) related to monthly blood pressure checks and weights. The findings are: Review of Resident #2's current FL2 dated 01/15/19 revealed diagnoses included dementia, schizoaffective disorder, and vitamin D deficiency. a. Review of Resident #2's current FL2 dated 01/15/19 revealed an order for monthly blood pressures. Review of Resident #2's physician order sheet dated 08/27/19 revealed an order for monthly blood pressures. Review of Resident #2's vitals sheets dated	C 249		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081052	A. BUILDING: ______ B. WING ______	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 3	**149 REID STREET FOREST CITY, NC 28043**

(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 1 02/01/19 to 07/28/19 revealed: -Resident #2's blood pressure had been documented for 34 occurrences and at least monthly as ordered from February to July 2019. -The range of the blood pressures were 113/68 to 182/133. -There were no blood pressure results documented after 07/28/19. Review of Resident #2's August 2019 to October 2019 Medication Administration Records (MARs) revealed there were no documented blood pressure results. Observation of Resident #2's blood pressure on 10/10/19 at 1:05pm revealed it was 141/93. Interview with a medication aide on 10/10/19 at 2:05pm revealed he did not know Resident #2 had an order for blood pressure checks to be done monthly. Telephone interview with the Administrator on 10/10/19 at 2:22pm revealed: -It was the facility's policy to document blood pressures on the vitals sheet when they were taken. -He did not know why staff had not documented the blood pressure checks. Telephone interview with Resident #2's psychiatric provider on 10/11/19 at 11:34am revealed: -The residents needed to have their blood pressures checked at least every month. -It was a "routine thing" for her to order blood pressures monthly. -The facility staff was "usually" good to get the blood pressures at the first of the month.	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081052	A. BUILDING: ______ B. WING ______	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 3	149 REID STREET FOREST CITY, NC 28043

(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 2	C 249		

b. Review of Resident #2's current FL2 dated 01/15/19 revealed an order for monthly weights.

Review of Resident #2's physician order sheet dated 08/27/19 revealed an order for monthly weights.

Review of Resident #2's vitals sheets dated 02/01/19 to 07/28/19 revealed:
-On 02/05/19, the documented weight was 170lbs.
-On 03/04/19, the documented weight was 170lbs.
-On 04/22/19, the documented weight was 170lbs.
-On 05/01/19, the documented weight was 170lbs.
-On 07/28/19, the documented weight was 165lbs.
-There were no weights documented after 07/28/19.

Review of Resident #2's August 2019 to October 2019 Medication Administration Records (MARs) revealed there were no documented weights.

Observation of Resident #2's weight on 10/10/19 at 1:00pm revealed it was 170lbs.

Interview with a medication aide on 10/10/19 at 2:05pm revealed he did not know Resident #2 had an order for weights to be done monthly.

Telephone interview with the Administrator on 10/10/19 at 2:22pm revealed:
-It was the facility's policy to document weights on the vitals sheet when they were taken.
-He did not know why staff had not documented the weights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081052	A. BUILDING: ______ B. WING ______	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 3	149 REID STREET FOREST CITY, NC 28043

(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 3 Telephone interview with Resident #2's psychiatric provider on 10/11/19 at 11:34am revealed: -The resident's needed to have their weights checked at least every month. -It was a "routine thing" for her to order weights monthly. -The facility staff was "usually" good to get the weights at the first of the month.	C 249		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (Resident #1) related to a medication for mood. The findings are: Review of Resident #1's current FL2 dated 09/18/19 revealed: -Diagnoses included depression, mental retardation, dementia, and gout. -There was an order for duloxetine (used to treat mood and pain) HCL DR 60mg once daily.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081052	A. BUILDING: ____ B. WING ____	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 3	**149 REID STREET** **FOREST CITY, NC 28043**

(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 330	Continued From page 4 Review of Resident #1's FL2 dated 01/15/19 revealed there was an order for duloxetine 60mg daily. Review of Resident #1's August 2019 through October 2019 Medication Administration Record (MARs) revealed: -There was an entries for duloxetine HCL DR 60mg once daily scheduled at 8:00am. -The duloxetine was documented as administered daily from 08/01/19 to 10/10/19. Observation of Resident #1's available medications on 10/10/19 at 10:32am revealed there was no duloxetine available for administration. Interview with the Owner on 10/10/19 at 10:35am and 11:25am revealed: -She had administered Resident #1's medications on 10/09/19. -On 10/09/19, she realized Resident #1 was down to his last dose of duloxetine and called the pharmacy to get it refilled. -The pharmacy had told her they would deliver the medication on the evening of 10/09/19. -The pharmacy did not tell her at that time the resident needed a new prescription to refill the medication. -The pharmacy was supposed to take care of refills. -If the pharmacy had trouble getting in touch with a physician then the facility staff would help them to contact the physician. Telephone interview with a representative from the facility's contracted pharmacy on 10/10/19 at 11:07am revealed: -The pharmacy had filled the duloxetine from a prescription dated 09/03/18.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081052	A. BUILDING: ______ B. WING ______	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 3	149 REID STREET FOREST CITY, NC 28043

(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 330	Continued From page 5 -The pharmacy required a new prescription to refill the duloxetine. -The representative had spoken with staff "a couple weeks ago" about getting a refill for the duloxetine, but the pharmacy had "never heard anything back" from facility staff. -The pharmacy would "normally" contact the prescribing practitioner for the facility however, Resident #1's prescribing practitioner did not accept faxes, so they asked the facility staff to "get in touch" with the prescribing practitioner for the refill. -The facility was last dispense of duloxetine 60mg was 30 tablets on 08/09/19. Review of Resident #1's medications listed on the facility's pharmacy delivery sheet dated 09/06/19 revealed there was no duloxetine 60mg tablets listed in the medications delivered for the resident. Interview with Resident #1 on 10/10/19 at 1:50pm revealed: -Facility staff gave him medications two times a day. -He was not sure if he had been getting the duloxetine. -Facility staff put his medications in a cup and "I take it." Interview with a medication aide on 10/10/19 at 2:05pm revealed: -He had administered the morning medications on 10/10/19. -He did not administer duloxetine to Resident #2 that morning. -He had last administered the duloxetine to Resident #2 on 10/08/19. Telephone interview with Resident #1's	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081052	A. BUILDING: ______ B. WING ______	C 10/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 3	149 REID STREET FOREST CITY, NC 28043

(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 330	Continued From page 6 psychiatric provider on 10/11/19 at 11:34am revealed: -She had prescribed the duloxetine for Resident #1 for mood and pain control in the resident's knee. -The facility staff had called her on 10/10/19 for a new prescription for the duloxetine so the medication could be refilled. -Resident #1 could probably miss a couple doses of the duloxetine a week without any side effects.	C 330		