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Division of	<u>of Health Service Regu</u>	llation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED
					F	₹
		FCL061008	B. WING		04/28/2021	
NAME OF D		PTDEET A	DDRESS, CITY, STA	TE ZID CODE		
INAIVIE OF P	ROVIDER OR SUPPLIER			,		
B & L FAN	MILY CARE HOME		IE CREEK ROAD SVILLE, NC 2870			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	(= , , , , , , , , , , , , , , , , , , ,		(X5) COMPLETE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	IATE DATE	DATE
				DEFICIENCY)		
C 000	Initial Comments		C 000			
	The Adult Care Licensure Section conducted an					
	annual and follow up survey on 04/28/21.					
C 375	10A NCAC 13G .100	9(a)(1) Pharmaceutical Care	C 375			
		9 Pharmaceutical Care				
	(a) The facility shall obtain the services of					
	licensed pharmacist, prescribing practitioner or registered nurse for the provision of					
	pharmaceutical care					
	· -	quently as determined by				
		ed on the documentation of				
		n problems identified during				
	monitoring visits or of	ther investigations in which				
	the safety of the resid	lents may be at risk.				
		involves the identification,				
	•	ution of medication related				
	· ·	des at least the following:				
	` '	tion review for each resident				
1	i which includes at leas	which includes at least the following:		1		1

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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

prescribing practitioner; and,

review in the resident's record;

(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

> TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
						R
		FCL061008	B. WING		04	1/28/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
B&LFAN	MILY CARE HOME		NE CREEK ROAD			
	OLIMANA DV. O		SVILLE, NC 28705	DDOV/IDEDIO DI ANI OFI	OODDECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 375	Continued From pag	e 1	C 375			
	facility failed to ensu	iews and interviews, the re quarterly pharmaceutical eted for 3 of 3 sampled				
	The findings are:					
	02/08/21 revealed di	nt #1's current FL2 dated agnoses included hepatic zure disorder, and chronic				
	Review of Resident revealed an admission	#1's Resident Register on date of 12/15/17.				
	revealed:					
	Refer to the interview 04/28/21 at 10:50am	v with the Administrator on 				
		ed telephone interview with nurse on 04/28/21 at				
	02/19/21 revealed di	nt #2's current FL2 dated agnoses included valve stenosis, and anxiety.				
	Review of Resident arevealed an admission	#2's Resident Register on date of 02/01/19.				
	revealed:	#2's pharmacy reviews acy review dated 03/07/19				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(V2) MULTIPLE	CONSTRUCTION	(V2) DATE CUDVEV	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _			
				R	
FCL061008		B. WING		04/28/2021	
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE ZIR CODE	
NAME OF T	NOVIDER OR GOLT EIER		E CREEK ROAD		
B & L FAN	IILY CARE HOME		SVILLE, NC 2870		
			VILLE, NC 2070		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	
TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
C 375	Continued From page	. 2	C 375		
0 373	Continued From page	; 2	03/3		
	that had no recomme	ndations.			
	-There were no other	pharmacy reviews.			
		with the Administrator on			
	04/28/21 at 10:50am.				
	5				
		d telephone interview with			
	the local health clinic	nurse on 04/28/21 at			
	11:20am.				
	3. Review of Resident #3's current FL2 dated				
	07/07/20 revealed diagnoses included				
	schizophrenia and depression.				
	Somzophichia and depression.				
	Review of Resident #3's Resident Register				
	revealed an admission date of 07/16/08.				
	Review of Resident #3's pharmacy reviews revealed:				
		cy review dated 03/07/19			
	that had no recomme				
	-There were no other	pnarmacy reviews.			
	Pofor to the interview	with the Administrator on			
	04/28/21 at 10:50am.	with the Administrator on			
	0+/20/21 at 10.00am.				
	Refer to the attempte	d telephone interview with			
	the local health clinic nurse on 04/28/21 at				
	11:20am.				
	Interview with the Adr	ministrator on 04/28/21 at			
	10:50am revealed:				
		for everything in the facility.			
	•	acy reviews were to be			
	completed every quar				
		health clinic had completed			
	the last pharmacy rev				
-She had just forgotten about the pharmacy					

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had a lot to do.

reviews and had not "kept up with it" because she

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
FCL061008			B. WING		04/28/2021	_
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
B & L FAN	MILY CARE HOME		CREEK ROAD			
	CLIMMADY CT		/ILLE, NC 2870	PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	I
C 375	Continued From page 3		C 375			
	Attempted telephone	interview with the local 04/28/21 at 11:20am was				

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