

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL061008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/28/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER B & L FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 842 CANE CREEK ROAD BAKERSVILLE, NC 28705
---	---

(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 an annual and follow up survey on 04/28/21.	C 000		
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. 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;	C 375		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL061008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/28/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER B & L FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 842 CANE CREEK ROAD BAKERSVILLE, NC 28705
---	---

(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 375	<p>Continued From page 1</p> <p>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 3 of 3 sampled residents (#1, #2, and #3).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 02/08/21 revealed diagnoses included hepatic encephalopathy, seizure disorder, and chronic pain.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 12/15/17.</p> <p>Review of Resident #1's pharmacy reviews revealed: -There was a pharmacy review dated 03/07/19 that had no recommendations. -There were no other pharmacy reviews.</p> <p>Refer to the interview with the Administrator on 04/28/21 at 10:50am.</p> <p>Refer to the attempted telephone interview with the local health clinic nurse on 04/28/21 at 11:20am.</p> <p>2. Review of Resident #2's current FL2 dated 02/19/21 revealed diagnoses included hypertension, aortic valve stenosis, and anxiety.</p> <p>Review of Resident #2's Resident Register revealed an admission date of 02/01/19.</p> <p>Review of Resident #2's pharmacy reviews revealed: -There was a pharmacy review dated 03/07/19</p>	C 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL061008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/28/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER B & L FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 842 CANE CREEK ROAD BAKERSVILLE, NC 28705
---	---

(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 375	<p>Continued From page 2</p> <p>that had no recommendations. -There were no other pharmacy reviews.</p> <p>Refer to the interview with the Administrator on 04/28/21 at 10:50am.</p> <p>Refer to the attempted telephone interview with the local health clinic nurse on 04/28/21 at 11:20am.</p> <p>3. Review of Resident #3's current FL2 dated 07/07/20 revealed diagnoses included schizophrenia and depression.</p> <p>Review of Resident #3's Resident Register revealed an admission date of 07/16/08.</p> <p>Review of Resident #3's pharmacy reviews revealed: -There was a pharmacy review dated 03/07/19 that had no recommendations. -There were no other pharmacy reviews.</p> <p>Refer to the interview with the Administrator on 04/28/21 at 10:50am.</p> <p>Refer to the attempted telephone interview with the local health clinic nurse on 04/28/21 at 11:20am.</p> <p>_____ Interview with the Administrator on 04/28/21 at 10:50am revealed: -She was responsible for everything in the facility. -She knew the pharmacy reviews were to be completed every quarter. -A nurse from a local health clinic had completed the last pharmacy reviews. -She had just forgotten about the pharmacy reviews and had not "kept up with it" because she had a lot to do.</p>	C 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL061008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/28/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER B & L FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 842 CANE CREEK ROAD BAKERSVILLE, NC 28705
---	---

(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 375	Continued From page 3 Attempted telephone interview with the local health clinic nurse on 04/28/21 at 11:20am was unsuccessful.	C 375		