PRINTED: 04/26/2021 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		FCL081054	B. WING		04/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD CITY, NC 28043		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 000	Initial Comments		C 000		
		sure Section conducted an I3/2021 through 04/14/2021.			
C 078	10A NCAC 13G .0315 Furnishings	5(a)(5) Housekeeping and	C 078		
	orderly manner, free of hazards;	nome shall: in uncluttered, clean and			
	failed to be maintaine	as evidenced by: s and interviews, the facility d in an uncluttered, clean ree of all obstructions and			
	The findings are:				
	hallway on 04/13/21 a -The area around the bathroom door had a grimeThe toilet had yellow front of the toilet to the -The rim of the toilet v yellowish brown splat -There was a thick lay the vinyl floor of the b	door handle on the brown sticky residue of shown spills down the e floor. was heavily soiled with ters.			

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD			
			CITY, NC 28043			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 078	Continued From page		C 078			
		long the top of the bathtub. yer of soap scum coating the hower walls.				
	at 9:56am revealed: -There was black grir the hallway along the resident roomsThere was black grir	ommon hallway on 04/13/21 me residue on the floors in e walls and leading into me residue around the door ading into the first resident				
	11:04am revealed: -The loveseat had un packages, and a cardThere was a cardbook loveseat on the floor stored on top of itThere was another 6 loveseat on the floorThere was black grir	with a 12 pack of soda 5 pack of soda in front of the me residue around the door ading into the family room				
	at 9:41am revealed: -The edge of the entrhandle had a brown solution of the entrhandle had a brown solution of the bedroom floor within the roomThe bathroom sink of drained very slowlyThere was an open lescattered around on the entry solution of the edge.	om that was accessed from drain contained debris and it bag of catfood that was				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 2 of 42

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD CITY, NC 28043			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
C 078	Continued From page 2		C 078			
	-The trashcan was ov -There was mold build and the rubber floor n	dup on the showers grout				
	dirty and had a browr -The shelves in the re residue and spilled fo -The kitchen counters boxes and cans of for	and door handles were a sticky residue of grime. frigerator contained a sticky od. s were cluttered with random od, dishes, pots and pans, led with clean dishes and				
	8:27am revealed: -The edge of the door of grimeThe deadbolt's escut -The weather-strippin was worn and outside door was closedThere was black grin	ont door on 04/14/21 at a had a brown sticky residue theon was missing. If you had a brown sticky residue theon was missing. If you had a brown sticky residue the door had a had a brown of the door had a had				
	revealed: -He cleaned the bath -He cleaned in order: Supervisor-in-Charge -He mopped the facili Interview with the SIC revealed: -The facility was swel common areas and in	ty floors everyday. C on 04/13/21 at 3:40pm ot and mopped daily in all				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 3 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		
		FCL081054	B. WING		04/14/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAI		
	OLUMBA DV OT		CITY, NC 28043		
(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 COMPLETE
C 078	Continued From page 3		C 078		
	day.	cleaned at least once a bathrooms daily and "wipe			
C 086	10A NCAC 13G .0318 Furnishings	5(b)(1) Housekeeping and	C 086		
	resident: (1) A bed equipped w or solid link springs at foam mattress. Hosp equipped shall be arrawater bed is allowed and permitted by the the following: This rule apply to net (A) at least one pillow (B) clean top and bott bed changed as ofter once a week; and	all have the following spair and clean for each ith box springs and mattress and no-sag innerspring or			
		n and interview the facility in 2 of 3 residents rooms			
	The findings are:				
	hall on the right on 0- -There were two beds	Iroom #3 at the end of the 4/13/21 at 9:52am revealed: s in the bedroom. n the door had a broken			

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 4 of 42

` '	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	FCL081054	B. WING		04/14/20	21
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ΓE, ZIP CODE		
LISA'S FAMILY CARE HOME # 1		T LAKE ROAL			
	FOREST CI	TY, NC 28043			
PREFIX (EACH DEFICIENCY MUST	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE CC	(X5) DMPLETE DATE
C 086 Continued From page 4		C 086			
bedframe and a broken boomattress to sag in the midd					
Interview with a resident or revealed: -He moved into the facility -His bed broke when he lai -The facility knew about the were in the process of getti Interview with the Supervis 04/13/21 at 9:59am reveale -He knew about the broker arranged to get a new oneThe new bed was schedul week. Interview with the SIC on 0 revealed all the mattresses been replaced throughout to last 2 years. 2. Observation of resident 10:04am revealed the mattright side of the room was gray color in various areas Interview with the Supervis 04/13/21 at 3:40pm revealed -All the mattresses and bed replaced throughout the fact yearsThe soiled mattress was " -He had tried putting plastic residents' mattresses to proresidents would tear the pla	a week ago. id on it last week. e broken bed and they ting him a new one. sor-in-Charge (SIC) on ed: n bed and had deled to arrive later this 04/13/21 at 3:40pm s and bedsprings had the facility within the room #2 on 04/13/21 at tress on the bed on the heavily soiled dark s on the mattress. sor-In-Charge (SIC) on ed: dsprings had been cility within the last 2 less than 2 years old." ic covers over all the rotect them, but the				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 5 of 42

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		
		FCL081054	B. WING		04/14/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LISA'S FA	MILY CARE HOME # 1		ST LAKE ROAL STY, NC 28043		
(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 APPROPE DEFICIENCY)	BE COMPLETE
C 112	Continued From page 5		C 112		
C 112	10A NCAC 13G .0318(a) Outside Premises		C 112		
	10A NCAC 13G .0318 Outside Premises 10A NCAC 13G .0318 Outside Premises (a) The outside grounds of new and existing family care homes shall be maintained in a clean and safe condition. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the outside grounds in a clean and safe condition.				
	The findings are:				
	Observations of the carport area on 04/13/21 at 9:30am revealed: -There was an iron chair with heavily soiled pink cushions with worn areas exposing the stuffing of the cushions. -There was an end table placed between a camp chair and a rocking chair and there was a piece of approximately 2 1/2 inch wide wood strip protruding 6 inches from the table top outward. -On top of a circular table in the middle of the carport, there was a round rusted metal plan, a rectangular rusted metal pan, 3 used styrofoam cups, a used paper plate, a plastic bowl with water, a metal pig, and a lamp with a plastic skull sitting on top of the lamp. -There was a trash bag of clothes on one chair. -There was a deflated plastic pool float lying on top of a 3 ft. long by 2 ft. wide empty cardboard box. -There were 2 wooden pallets resting against the				
	the wooden pallets.	llon buckets of paint behind ed cardboard box leaned			

Division of Health Service Regulation

STATE FORM 6899 3S8011 If continuation sheet 6 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD CITY, NC 28043			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 112	There were work glocontainer of disinfectidarts lying on the brid Observations of the south of the standing freeze located was sticky to the edge of the door. Observations of the fiparking area on 04/13. The grass on the rig on the yard near the inches high. The grass on the buarea was approximated interview with the Su 04/13/21 at 3:40pm relit had been "difficult" the facility as they had "construction matter to back yards and they lawnmower "out of the They had recently has system, and the draired the south of the system, and the draired the sitems on the back of clothes see the gone through and the items sitting on	eves, a cooking pot, a ling wipes, a tarp, and four ck side wall of the carport. Screened back porch area on revealed the side of the door er where the handle was the touch and coated down with black grime. Front yard, side yard, and 3/21 at 11:06am revealed: ht side of the front yard and road was approximately 6 lilding side of the parking ely 6 inches high. Pervisor-In-Charge (SIC) on evealed: 'to get the grass cut around d recently had a going on" in the front and had just gotten their e shop." and to work on the well, septic mage for "about a week." itting in the chair needed to distributed to the residents. the tables belonged to one the resident would be "upset"	C 112			
C 202	Medical Examination		C 202			
	Medical Examination	2 Tuberculosis Test and to a family care home each				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 7 of 42

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1	542 FOR	EST LAKE ROAD			
LIOAOTA	MILI GARL HOME # 1	FOREST	CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 202	resident shall be tested in compliance with the by the Commission for specified in 10A NCA subsequent amendmenthe rule are available the Department of He Tuberculosis Control Center, Raleigh, North This Rule is not met Based on record revisional states.	ed for tuberculosis disease e control measures adopted or Health Services as C 41A .0205 including ents and editions. Copies of at no charge by contacting ealth and Human Services, Program, 1902 Mail Service h Carolina 27699-1902.	C 202	DETIGLA		
	Review of Resident # 04/14/21 revealed diadementia, chronic obsand gastresophageal Review of Resident # -His Resident Registe he was admitted to the -There was no docum (TB) test. Interview with the Support of the thought Resident admission. -He did not know why not in his record. -He attempted to obta Resident #1's Primary	agnoses included diabetes, structive pulmonary disease reflux disease. 1's record revealed: er dated 03/31/16 revealed e facility on 03/31/16. nentation of a tuberculosis				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 8 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SU COMPLE		
		FCL081054	B. WING		04/14	/2021
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		ST LAKE ROAL SITY, NC 28043			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 202	Continued From page 8		C 202			
	local health department may have documentation.					
C 249	10A NCAC 13G .0902	2(c)(3)(4) Health Care	C 249			
	following in the reside (3) written procedure a physician or other li and (4) implementation or	assure documentation of the				
	This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure blood sugar levels were documented as ordered for 1 of 3 sampled residents (Resident #1) who had an order for finger stick blood sugar (FSBS) checks on Monday, Wednesday and Friday.					
	The findings are:					
	revealed:	ix disease. for FSBS checks on				
	through 03/07/21 reve	d (MAR) dated 02/08/21 ealed: o check FSBS on Monday,				

Division of Health Service Regulation

STATE FORM 6899 3S8011 If continuation sheet 9 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '		(X3) DATE SURVEY COMPLETED		
			R WING	B. WING		_
		FCL081054	D. WING		04/14/2021	ı
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD			
			CITY, NC 28043			
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMF	(5) PLETE ATE
C 249	Continued From page 9		C 249			
	-There was documentation that FSBS were checked 12 of 12 opportunitiesThere was no documentation of the FSBS results for 12 of 12 opportunities.					
	through 04/04/21 revolutions through 04/04/21 revolutions. There was an entry the Wednesday and Fridar There was document checked 11 of 12 opp	o check FSBS on Monday, ay. tation that FSBS were portunities. nentation of the FSBS				
	through 05/04/21 reverse through 05/04/21 reverse was an entry to the Wednesday and Frida -There was documen checked 4 of 4 oppor	to check FSBS on Monday, ay. tation that FSBS were tunities. nentation of the FSBS				
	04/14/21 at 8:46am re-Resident #1's FSBS Wednesday and Frida-When he checked th MAR. -The FSBS results for	were checked on Monday, ay. e FSBS he initialed the r Resident #1 were parate piece of paper but he				
	Wednesday and Frida	nt #1's FSBS on Monday, ay. ere he put the piece of paper				

Division of Health Service Regulation

-The piece of paper paper was usually kept in a

STATE FORM 8899 3S8011 If continuation sheet 10 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		FCL081054	B. WING		04/1	4/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LICAICEA	MILV CARE HOME # 4	542 FORES	ST LAKE ROAL			
LISA S FA	MILY CARE HOME # 1	FOREST C	ITY, NC 28043	ı		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
C 249	Continued From page 10		C 249			
	folder near the reside	nt's glucometer.				
	Interview with Resident #1 on 04/14/21 at 10:45am revealed his FSBSs was checked three times a week.					
C 315	10A NCAC 13G .1002	2(a) Medication Orders	C 315			
	the resident's physicial for verification or clari medications and treat (1) if orders for admission admission or readmission or readmissions are not the sam The facility shall ensure	ne shall ensure contact with an or prescribing practitioner ification of orders for tments: sion or readmission of the d and signed within 24 hours nission to the facility; lear or complete; or on forms are received upon sion and orders on the				
	failed to ensure conta prescribing practitions for 2 of 3 sampled res regards to a medication supplement to increase medication to treat ur #1), a medication to to	ew and interview the facility not with the residents er for clarification of orders sidents (Resident #1 & #2) in on to treat fluid retention, a se vitamin D levels, a inary retention (Resident reat irritable bowel pplements and a fiber				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 11 of 42

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		FCL081054	B. WING		04	1/14/2021
NAME OF D			DDDECC CITY CTATE	710.0005		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD CITY, NC 28043			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 315	Continued From page	2 11	C 315			
	03/24/21 revealed: -Diagnoses included diabetic ulcer, hypertedisease and urinary retrievals an order of fluid retention) 40mg -There was an order of supplement vitamin domodayThere was an order of urinary retention) 0.4rd Review of Resident # revealed: -There was an order of needed for swellingThere was an order of daily.	etention. for furosemide (used to treat daily. for Vitamin D3 (used to levels) 1250mg every for flomax (used to treat				
		1's record revealed there tion orders available for				
	through 04/04/21 reverse through 04/04/21 reverse was an entry from the first with an order date of administered daily from 04/04/21. There was an entry from the first with 40mg furosemide 02/02/21 documented 03/08/21 through 04/04-11 reverse was an entry from the first was an ent	d (MAR) dated 03/08/21 ealed: for furosemide 40mg daily 03/01/21 documented as m 03/08/21 through for furosemide 20mg daily e with an order date of d as administered daily from				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 12 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S		
			A. BUILDING: _			
		FCL081054	B. WING		04/1	4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
I ISA'S FA	MILY CARE HOME # 1	542 FORES	ST LAKE ROAI			
	ET GARE HOME # 1	FOREST C	ITY, NC 28043	3		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 315	Continued From page	e 12	C 315			
	02/09/21 not docume 03/08/21 through 04/0-There was an entry f every Monday and Th 03/01/21 that had Thi documented as admin 03/08/21, 03/15/21, 0 Thursday 03/25/21, V Friday 04/02/21. -There was not an en Mondays with an order date of There was not an en with an order date of Review of Resident # through 05/04/21 reversional throug	nted as administered from 04/21. for Vitamin D 50,000 units hursday with an order date of cursday marked out and was nistered on Mondays 3/22/21 and 03/29/21, Vednesday 03/31/21 and try for Vitamin D 1250mg on er date of 03/24/21. try for flomax 0.4mg daily 03/24/21. 1's MAR dated 04/05/21 ealed: for furosemide 40mg daily 03/02/21 that was crossed as a duplicate. for furosemide 20mg daily e with an order date of				
	documented as admir 04/05/21 and 04/12/2	nistered on Mondays				
		try for Vitamin D 1250mg on				
	Mondays with an order					
	with an order date of	try for flomax 0.4mg daily 03/24/21.				
	3:00pm revealed:	nager and the e (SIC) on 04/13/21 at curned from the hospital they				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 13 of 42

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		REST LAKE ROAD			
	T	FORES	CITY, NC 28043			
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	different so they cont Provider (PCP) for cl-The PCP instructed medications as previous evaluate Resident #1 ordersResident #1 saw the medication orders but paperwork they receive the facility's contracted 9:09am revealed: -They did not receive for Resident #1 or recoive for Resident #1 or Resident	ons listed on the FL2 were acted the Primary Care arification. them to continue ously ordered until she could and adjust medication PCP and received new at they could not locate the				
	-They had an order of furosemide 40mg dai received an order to needed for swelling. Refer to the telephon contracted facility phis 1:42pm. Refer to the interview Manager on 04/13/2 2. Review of Resider revealed: -Diagnoses included depression, and irritariater was an order	ily and on 03/02/21 they change it from daily to as the interview with the armacy on 04/13/21 at with the SIC and the I at 3:00pm. Int #2's FL2 dated 02/10/21 diabetes, bipolar disorder,				

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 14 of 42

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING				
		FCL081054	B. WING		04/14/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE			
I ISA'S FA	MILY CARE HOME # 1	542 FOR	EST LAKE ROAL)			
		FOREST	CITY, NC 28043				
(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 APPROPE DEFICIENCY)	BE COMPLETE	E	
C 315	Continued From page	: 14	C 315				
	irritable bowel syndro daily. Review of Resident #						
	Administration Record 03/07/21 revealed:	d (MAR) dated 02/08/21 to					
	tablet daily at 8:00am administered daily fro 03/07/21. -There was an entry fro tablet daily at 8:00am administered daily 02. -There was an entry fro capsule daily at 8:00a administered daily 02. -There was an entry fro vitamin supplement of documented as administered daily 03/07/21. -There was an entry fro zinc levels of 50mg 1 to documented as administered a	or vitamin D3 1000 units 1 documented as /08/21 through 03/07/21. or Linzess 290mcg 1 am documented as /08/21 through 03/07/21. or multivitamin (used as a 1 tablet daily at 8:00am histered daily 02/08/21 or zinc (used to supplement ablet daily at 8:00am histered daily 02/08/21 or vitamin C (used to s levels)500mg 1 tablet daily at a administered daily ed as administered daily					
	treat constipation) 2 c scheduled at 8:00am administered twice da 03/07/21.	apsules two times a day and 8:00pm documented as					
	04/07/21 revealed: -There was an entry f	or vitamin D3 2000 units 1					

Division of Health Service Regulation

tablet daily at 8:00am documented as

STATE FORM 8899 3S8011 If continuation sheet 15 of 42

	IDENTIFICATION NUMBER:	* *	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	FCL081054	B. WING		04/1	4/2021
NAME OF PROVIDER OR SUPPLIER LISA'S FAMILY CARE HOME # 1	542 FORES	RESS, CITY, STATE T LAKE ROAD TY, NC 28043			
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
administered daily from 03 04/04/21. -There was an entry for vit tablet daily at 8:00am door administered daily from 03 04/04/21. -There was an entry for Lin capsule daily at 8:00am do administered daily from 03 04/04/21. -There was an entry for mat 8:00am documented as from 03/08/21 through 04/-There was an entry for zir at 8:00am documented as from 03/08/21 through 04/-There was an entry for vit daily at 8:00am documented daily from 03/08/21 through -There was an entry for fib two times a day scheduled documented as administer 03/08/21 through 04/04/21 Review of Resident #2's M 05/04/21 revealed: -There was an entry for vit tablet daily at 8:00am door administered daily from 04/04/121. -There was an entry for Vit tablet daily at 8:00am door administered daily from 04/04/14/21. -There was an entry for Lin capsule daily at 8:00am documented daily from 04/04/14/21. -There was an entry for Lin capsule daily at 8:00am documented daily from 04/04/14/21. -There was an entry for Lin capsule daily at 8:00am documented daily from 04/04/14/21. -There was an entry for Lin capsule daily at 8:00am documented daily from 04/04/14/21. -There was an entry for Lin capsule daily at 8:00am documented daily from 04/04/14/21. -There was an entry for Lin capsule daily at 8:00am documented daily from 04/04/14/21. -There was an entry for Market daily from 04/04/14/21. -There was an entry for market daily from 04/04/14/21. -There was an entry for market daily from 04/04/14/21.	tamin D3 1000 units 1 sumented as 3/08/21 through Inzess 290mcg 1 ocumented as 3/08/21 through sultivitamin 1 tablet daily sadministered daily /04/21. nc 50mg 1 tablet daily sadministered daily /04/21. tamin C 500mg 1 tablet ted as administered gh 04/04/21. per laxative 2 capsules d at 8:00am and 8:00pm red twice daily from 1. MAR dated 04/05/21 to tamin D3 2000 units 1 sumented as 4/05/21 through nzess 290mcg 1 ocumented as 4/05/21 through	C 315			

Division of Health Service Regulation

at 8:00am documented as administered daily

STATE FORM 8899 3S8011 If continuation sheet 16 of 42

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL081054	B. WING		04/14	4/2021	
	PROVIDER OR SUPPLIER	542 FORE	DRESS, CITY, STA ST LAKE ROAI CITY, NC 28043	D			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE	
C 315	from 04/05/21 through -There was an entry fat 8:00am documente from 04/05/21 through -There was an entry fat 8:00am documente from 04/05/21 through -There was an entry fat wo times a day sche documented as admin 04/05/21 through 04/05/20 through 120/05/20 through 120/05/20 through 120/05/20 through 120/05/20 through 120/05/21 through	or zinc 50mg 1 tablet daily and as administered daily in 04/14/21. For vitamin C 500mg 1 tablet mented as administered daily in 04/14/21. For vitamin C 500mg 1 tablet mented as administered daily from 14/21. For fiber laxative 2 capsules duled at 8:00am and 8:00pm instered twice daily from 14/21. For fiber laxative 2 capsules duled at 8:00am and 8:00pm instered twice daily from 14/21. For fiber laxative 2 capsules duled at 8:00am and 8:00pm instered twice daily from 14/21. For fiber laxative 2 capsules duled at 8:00am and 8:00pm instered twice daily from 14/21. For fiber laxative 2 capsules duled at 8:00am and 8:00pm instered twice daily was a sived for Resident #2 on 14 tablet daily was a sived for Resident #2 on 14 tablet daily was a prescription ident #2 on 01/25/21. For fiber laxative 2 capsules daily was a prescription ident #2 on 01/25/21. For fiber laxative 2 capsules daily was a prescription ident #2 on 01/25/21. For fiber laxative 2 capsules twice a day was a sived for Resident #2 on 14 tablet daily was a prescription ident #2 on 01/25/21. For fiber laxative 2 capsules twice a day was a sived for Resident #2 on 14 tablet daily was a prescription ident #2 on 01/25/21. For fiber laxative 2 capsules twice a day was a sived for Resident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a prescription ident #2 on 14 tablet daily was a pres	C 315				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 17 of 42

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		, , ,	E SURVEY IPLETED
		FCL081054	B. WING		0.	4/14/2021
			1		1 0.	+/ 14/2021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD			
		FOREST	CITY, NC 28043			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 315	Continued From page	e 17	C 315			
	contracted facility phate 1:42pm revealed: -They provided component for the facilityThey considered FL: orders for medicationThe facility was respectanged orders theyThey changed and a and change orders we practitioners or presecting currently did not changed orders or electrically to the pharma facility requested a contract of the phate of the	onsible for faxing any new or received to the pharmacy. Iltered orders based on new ritten by prescribing riptions they received. On the provide copies of new and ectronic prescriptions sent acy to the facility unless the opy of an order. Cand the Manager on evealed: Is to the pharmacy as soon by the primary care provider pharmacy accepted FL2s as rs. In the pharmacy did not accept responsible for updating and each month. In medication change orders printed, they hand wrote the				
	discontinued across t	ntry on the MAR and wrote he MAR entry for the changed or discontinued.				
C 320	10A NCAC 13G .100	2 (f) Medication Orders	C 320			
	10A NCAC 13G .100	2 Medication Orders				
	(f) The facility shall a	ssure that all current orders				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 18 of 42

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, , ,	E SURVEY PLETED
		FCL081054	B. WING		04	/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	•	
	MILV CARE HOME #4	542 FOR	EST LAKE ROAD			
LISA'S FA	MILY CARE HOME # 1	FOREST	CITY, NC 28043			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 320	Continued From page	e 18	C 320			
	for medications or tre orders and orders for reviewed and signed	atments, including standing self-administration, are by the resident's physician oner at least every six				
	orders for medication reviewed and signed	n, record review and ailed to ensure that current s or treatments were by the resident's prescribing very six months for 3 of 3				
	The findings are:					
	1. Review of Residen 04/14/21 revealed: -Diagnoses included obstructive pulmonary gastroesophageal ref diabetes and schizoa -It was signed by his -There was an order treat anxiety) 30mg or -There was an order supplement Vitamin 0 dailyThere was an order of the vitamin 1 daily.	y disease (COPD), flux disease (GERD), ffective disorder. Primary Car Provider (PCP). for duloxetine HCL (used to ne capsule every day. forVitamin C (used to c intake) 500mg 1 capsule for a multivitamin one tablet for Vitamin D3 (used to c levels) 1000unit tablet for Zinc (used to supplement ne tablet every night. for digoxin (used to treat				
	diabetes) 10mg one t	for jardiance (used to treat				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 19 of 42

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
		FCL081054	B. WING		04/1	4/2021
					1 0	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
LISA'S FA	MILY CARE HOME # 1		ST LAKE ROAI			
	_	FOREST (OITY, NC 28043	3		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
170		,	170	DEFICIENCY)		
	0 (; 15	10	0.220			
C 320	Continued From page	e 19	C 320			
	heart attack) 81mg or					
	-There was an order f	for clopidogrel (used to treat				
	coronary heart diseas	se) 75mg one capsule daily.				
	-There was an order f	for duloxetine HCL 60mg				
	one capsule every da					
		for anoro ellipta (used to				
		ncg, inhale 1 puff every day.				
		for vitamin D 50000 units				
	one capsule every Mo					
		for doxycycline HYC (used				
		mg one tablet 2 times a day.				
		for isosorbide MN (used to				
		g 1 tablet twice a day.				
		for ranolazine ER (used to				
	i	ng 1 tablet two times a day.				
		for hydroxyzine PAM (used				
		25mg 1 capsule three times				
	a day.					
		for ondanestron HCL(used				
		1 tablet three times a day.				
		for baclofen (used to treat				
		olet three times a day. for clonazepam (used to				
		one tablet four times a day. for mirtazapine (used to				
	treat anxiety) 45mg 1					
	., .	for zolpidem tartrate (used				
	to treat anxiety) 5mg	· · · · · · · · · · · · · · · · · · ·				
		for gabapentin (used to treat				
		ng one tablet at bedtime.				
		for quetiapine FUM (used to				
		disorder) 400mg one tablet				
	at bedtime.	alcordory rooming one tablet				
		for prazosin HCL (used to				
		mg one capsule at bedtime.				
	,	for fenofibrate (used to treat				
		se) 48mg one tablet daily.				
		for atorvastatin (used to				
	treat cholesterol) 40m	· ·				
		for risperidone (used to treat				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 20 of 42

	or riealth Service Regu		T		T	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S COMPL	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPL	ETED
		FCL081054	B. WING		04/	14/2021
NAME OF D		OTDEETAD		TE 710 000E		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
LISA'S FA	MILY CARE HOME # 1		ST LAKE ROA			
	ı	FOREST	CITY, NC 28043	3		1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API		COMPLETE DATE
TAG	REGULATORY OR I	EGO IDENTIL TING INI GRAVIATION)	TAG	DEFICIENCY)	ROTRIATE	
			0.000			
C 320	Continued From page	e 20	C 320			
		ler) 2mg one tablet every				
	night at bedtime.					
	-There was an order	for furosemide (used to treat				
	fluid retention) 40mg	one tablet if needed for				
	swelling					
		to check blood sugars 3				
	times a week.	for boro allinta (used to treat				
	COPD) 100-25mcg o	for bero ellipta (used to treat				
		for oxycodone (used to treat				
	pain) 10mg-325 one t	- ,				
	pairi) foring-323 one i	tablet 4 times a day.				
	Review of Resident #	1's FL2 dated 03/24/21				
	revealed:					
	_	depressive disorder, diabetic				
		hronic kidney disease and				
	urinary retention.					
		physician discharging him				
	from a local hospital.	for flore as (
		for flomax (used to treat				
	urinary retention) 0.4	mg dally. for ambian (used to treat				
		•				
	sleep disorder) 5mg r	for aspirin 81mg daily.				
		for a multivitamin daily.				
		for digoxin 125mg daily.				
		for duloxetine 60mg_daily.				
		for imdur ER 60mg twice a				
	day.	ioi iiiiddi EN oonig twice a				
		for jardiance 10mg each				
	morning.	ja. didi iso Tomig odon				
		for klonopin four times a				
	day.	,				
	_ ·	for lactulose 10gm/15ml,				
	15ml daily.	3 ,				
	-There was an order	for lasix 40mg daily.				
		for lioresal 10mg three times				
	a day.	-				
	-There was an order	for lipitor 40mg daily.				
	-There was an order	for lopressor 25mg three				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 21 of 42

STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			5				
		FCL081054	B. WING		04/1	4/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
LISA'S FA	MILY CARE HOME # 1	542 FORE	ST LAKE ROAI	D			
		FOREST	CITY, NC 28043	3		r	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 320	Continued From page	21	C 320				
C 320	times a day. -There was an order to bedtime. -There was an order to bedtime. -There was an order to a day. -There was an order to bedtime. -There was an order to bedtime. -There was an order to day. -There was an order to bedtime. -There was an order to bedtime. -There was an order to to a day. -There was an order to to a day. -There was an order to a day. -There was an order to day. -T	for prazosin 2mg daily at for neurontin 600mg at for norco 10/325 four times for plavix 75mg daily. for seroquel 400mg at for ranexa 500mg twice a for remeron 45mg at for risperdal 2mg at bedtime. for tricor 48mg daily. for vibramycin 100mg twice for vistaril 25mg three times for vitamin c 500mg daily. for vitamin D3 1250mg each for zinc 50mg at bedtime. for zofran 4mg three times a for breo-ellipta 100-25mcg 1 for anoro-ellipta 62.5-25mcg 1's FL2 dated 02/10/21 dementia, COPD, GERD, ession and schizoaffective	C 320				
	-There was an order of bedtimeThere was an order of dayThere was an order of bedtimeThere was an order of bedtimeThere was an order of the company of the companyThere was an order of a dayThere was an order of a day as neededThere was an order of a day as neededThere was an order of the companyThere was an order of the compan	for seroquel 400mg at for ranexa 500mg twice a for remeron 45mg at for risperdal 2mg at bedtime. for tricor 48mg daily. for vibramycin 100mg twice for vistaril 25mg three times for vitamin c 500mg daily. for vitamin D3 1250mg each for zinc 50mg at bedtime. for zofran 4mg three times a for breo-ellipta 100-25mcg 1 for anoro-ellipta 62.5-25mcg 1's FL2 dated 02/10/21 dementia, COPD, GERD, ression and schizoaffective PCP. for duloxetine HCL 30mg					

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 22 of 42

DIVISION	n nealth Service Negu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		FCL081054	B. WING		04/14/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		542 FORE	ST LAKE ROA	D	
LISA'S FA	MILY CARE HOME # 1		CITY, NC 28043		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
			4	DEI IGIENCI)	
C 320	Continued From page	22	C 320		
	daily.				
	•	for a multivitamin one tablet			
	daily.				
	•	for Vitamin D3 1000 unit			
	tablet daily.				
	-There was an order f	for Zinc 50mg one tablet at			
	bedtime.	-			
	-There was an order t	for aspirin 81mg one tablet			
	daily.				
	-There was an order f	for clopidogrel 75mg one			
	tablet daily.				
	-There was an order t	for duloxetine HCL 60mg			
	one capsule every da				
		for anoro ellipta 62.5-25mcg,			
	inhale 1 puff every da	· -			
	-There was an order tablet daily.	for jardiance 10mg one			
	 There was an order face capsule daily. 	for vitamin D 5000units one			
	-There was an order f	for doxycycline HYC 100mg			
	one tablet 2 times a d	lay.			
	-There was an order t	for isosorbide MN 60mg 1			
	tablet twice a day.				
		for ranolazine ER 500mg 1			
	tablet two times a day				
		for hydroxyzine PAM 25mg 1			
	capsule three times a				
		for ondanestron HCL 4mg 1			
	tablet three times a day				
	three times a day.	for baclofen 10mg 1 tablet			
	-	for clonazepam 0.5mg one			
	tablet four times a day				
		y. for mirtazapine 45mg 1			
	tablet at bedtime.	· · · · ·			
		for zolpidem tartrate 5mg 1			
	tablet at night.	for prozecin LICL 2			
	capsule at bedtime.	for prazosin HCL 2mg one			

Division of Health Service Regulation

-There was an order for fenofibrate 48mg one

STATE FORM 8899 3S8011 If continuation sheet 23 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
	FCL081054	B. WING		04/14/2021
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
LISA'S FAMILY CARE HOME # 1	542 FORE	ST LAKE ROAI	D	
	FOREST	CITY, NC 28043	3	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
C 320 Continued From pa	ge 23	C 320		
tablet daily. -There was an order tablet daily. -There was an order tablet at bedtime. -There was an order tablet at bedtime. -There was an order tablet at bedtime. -There was an order tablet four times and the sugars was an order tablet four times and the sugars Monday, where the was an order tablet four times and the sugars Monday, where the was an order tablet four times and the sugars was an order tablet four times and the sugars was an order tablet four times and tablet	r for atorvastatin 40mg one r for quetiapine FUM 400mg ne. r for gabapentin 600mg one r for glucose test strips every ay and Friday. r for hydrocodone 7.5/325 one lay as needed. r for lasix 40mg one tablet as . r for digoxin 125mcg daily, r for lancets to check blood ednesday and Friday. r for bero-ellipta 100-25mcg r metoprolol 25mg one tablet #1's record revealed: dated 02/10/20. completed a six month review ween the FL2 dated 02/10/20 02/10/21. ident #1's available 13/21 at 3:55pm revealed			

Division of Health Service Regulation

strips and lancets were available for

STATE FORM 8899 3S8011 If continuation sheet 24 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C			E SURVEY PLETED
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
		542 FOF	REST LAKE ROAD			
LISA'S FA	MILY CARE HOME # 1	FORES ⁻	T CITY, NC 28043			
(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 CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
C 320	Continued From page	e 24	C 320			
	administration.					
	Refer to the interview Supervisor-In-Charge	v with the e on 04/13/21 at 10:45am.				
	Refer to the interview with the Manager on 04/13/21 at 2:20pm. 2. Review of Resident #2's current FL2 dated 04/14/21 revealed: -Diagnoses included diabetes, bipolar disorder, depression, and irritable bowel syndromeThere was an order for acidophilus probiotic (used to treat constipation) 1 tablet dailyThere was an order for aspirin EC (used to prevent blood clots) 81mg 1 tablet dailyThere was an order for atorvastatin (used to treat high cholesterol) 80mg 1 tablet dailyThere was an order for cyanobalamin (used to supplement vitamin B12 levels) 1000mcg/ml inject 1ml once a month.					
	to treat pain) 1% gel times a dayThere was an order to treat constipation) a dayThere was an order	for diclofenac sodium (used apply to affected area two for docusate sodium (used 100mg 2 capsules two times for fiber laxative (used to				
	diabetes) 10mg 1 tab -There was an order treat anxiety) 50mg 1 -There was an order treat bipolar disorder once a month.	for glipizide (used to treat olet two times a day. for hydroxyzine (used to I capsule three times a day. for Invega sustenna (used to) 234mg inject into muscle for lisinopril (used to treat				
	-There was an order	for Linzess (used to treat ome) 290mcg 1 capsule				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 25 of 42

DIVISION	n Health Service Negu	lation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE S	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED	
		FCL081054	B. WING		04/	14/2021	
NAME OF D	20//DED OD OUDDUED	070557.405	DEGG OITY OTA				
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	•			
LISA'S FA	MILY CARE HOME # 1		ST LAKE ROA				
2.07.017.		FOREST C	ITY, NC 28043	3			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)	
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP	ROPRIATE	DATE	
			1	DEFICIENCY)			
C 320	Continued From page	25	C 320				
	Continuou i rom page	7.20					
	daily.						
	-There was an order f	for lamotrigine (used to treat					
	bipolar disorder) 200r	ng 1 tablet two times a day.					
	• ,	for lithium carbonate (used					
		er) 300mg 2 capsules two					
	times a day.	or, cooming 2 superiors the					
		for metformin (used to treat					
		,					
	, .	ablet two times a day.					
		for multivitamin (used as a					
	vitamin supplement) '						
		for ondansetron (used to					
	treat nausea) 4mg 1 t	ablet dissolve on tongue					
	three times a day.						
	-There was an order f	for paliperidone (used to					
		ER 3mg take 1 tablet daily.					
	-	for pantoprazole (used to					
		al reflux) 40mg 1 tablet two					
	times a day.	arrenax) formy rabbet two					
	-	for prozesia (used to treet					
		for prazosin (used to treat					
		2mg 1 capsule at bedtime.					
		for pregabalin (used to treat					
	pain) 50mg 1 capsule						
		for trazodone (used to treat					
	depression) 100mg 1	tablet at bedtime.					
	-There was an order f	for vitamin C (used to					
	supplement vitamin C	levels) 500mg 1 tablet					
	daily.	,					
	_	for vitamin D3 (used to					
		03 levels) 2000 units 1 tablet					
	daily.						
		for vitamin D3 1000 units 1					
	capsule daily.	or vitalinii Do 1000 ullita 1					
		for zing (upod to cumplement					
		for zinc (used to supplement					
	zinc levels) 50mg 1 ta	ablet dally.					
	Deview of Deside 19	Ola El O data d 00/40/04					
		2's FL2 dated 02/10/21					
	revealed:						
		diabetes, bipolar disorder,					
	depression, and irrital	ble bowel syndrome.					

Division of Health Service Regulation

-There was an order for acidophilus probiotic 1

STATE FORM 8899 3S8011 If continuation sheet 26 of 42

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			B. WING		l	
		FCL081054	B. WING		04/1	4/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		542 FOR	EST LAKE ROA	n		
LISA'S FA	MILY CARE HOME # 1		CITY, NC 2804			
			JII 1, NO 2004			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		,	,,,,,	DEFICIENCY)		
C 320	Continued From page 26		C 320			
	tablet daily.					
	-	for aspirin EC 81mg 1 tablet				
	daily.	ioi aspiriii 20 0 mig i tabict				
	•	for atorvastatin 80mg 1				
	tablet daily.	ioi atorvastatiii oomg i				
	-There was an order f	for cyanobalamin				
	1000mcg/ml inject 1ml once a monthThere was an order for diclofenac sodium 1%					
	gel apply to affected area two times a day.					
	•	for docusate sodium 100mg				
	2 capsules two times					
	•	for glipizide 10mg 1 tablet				
	two times a day.	or gripizide rorng i tablet				
	-	for hydroxyzine 50mg 1				
	capsule three times a					
		for Invega sustenna 234mg				
	inject into muscle onc					
	•	for vitamin D3 2000 units 1				
	tablet daily.	ioi vitainiii Bo 2000 units 1				
	-	for lamotrigine 200mg 1				
	tablet two times a day	•				
	-There was an order f					
	capsule daily.	ior Emileos i Tomog i				
		for lisinopril 2.5mg 1 tablet				
	daily.	.og :				
	,	for lithium carbonate 300mg				
	2 capsules two times					
	· · · · · · · · · · · · · · · · · · ·	for metformin 1000mg 1				
	tablet two times a day	•				
		for ondansetron 4mg 1				
		gue three times a day as				
	needed.	,				
	-There was an order t	for pantoprazole 40mg 1				
	tablet two times a day					
		for paliperidone ER 3mg			ĺ	
	take 1 tablet daily.					
	-	for prazosin 2mg 1 capsule				
	at hedtime	. 5				

Division of Health Service Regulation

capsule at bedtime.

-There was an order for pregabalin 50mg 1

STATE FORM 8899 3S8011 If continuation sheet 27 of 42

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		EIED	
		FCL081054	B. WING		04/14/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
I ISA'S EA	MILY CARE HOME # 1	542 FORE	ST LAKE ROAI	D			
LISASTA	IMILI CARE HOME # 1	FOREST C	ITY, NC 28043	3			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
C 320	Continued From page	e 27	C 320				
	-There was an order to at bedtime.	for trazodone 100mg 1 tablet					
	•	ated 11/01/19.					
	Observation of Resident #2's available medications on 04/13/21 at 1:25pm revealed aspirin, vitamin D3 2000u and 1000u capsules, Linzess, atorvastatin, lisinopril, lamotrigine, lithium carbonate, docusate sodium, pantoprazole, glipizide, metformin, trazodone, pregabalin, prazosin, hydroxyzine, ondansetron, cyanocobalamin, Invega Sustenna, diclofenac, paliperidone, acidophilus probiotic, multivitamin, zinc, vitamin C, and fiber laxative capsules were available for administration.						
	Refer to the interview 04/13/21 at 10:45am.						
	Refer to the interview with the Supervisor-In-Charge (SIC) on 04/13/21 at 2:20pm. 3. Review of Resident #3's current FL2 dated 02/10/21 revealed: -Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), asthma, hepatitis C, mood disorder, irritable bowel syndrome, and gastroesophageal reflux diseaseThere was an order for vitamin D3 (used to supplement vitamin D3) 400u 1 capsule dailyThere was an order for vitamin D3 1000u 1 capsule dailyThere was an order for benxtropine (used to						

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 28 of 42

DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL081054	B. WING		04/14/2021
		FCE001034			04/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
1 10 A 10 EA	LISA'S FAMILY CARE HOME # 1			D	
LISASTA	WILL CARE HOWE # 1	FOREST (OITY, NC 28043	3	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
C 320	Continued From page	e 28	C 320		
	treat extrapyramidal s	symptoms caused by use of			
	antipsychotic medicat	tions) 1 mg 1 tablet daily.			
	-There was an order t	for risperidone (used to treat			
	mood disorder) 2mg	1 and 1/2 tablets daily.			
	-There was an order f	for risperidone 2mg 1 tablet			
	at bedtime.				
		for azithromycin (used to			
	treat infection) 250m	•			
		for multivitamin (vitamin			
	supplement) 1 tablet daily.				
	-There was an order t	,			
		levels) 500mg 1 tablet			
	daily.				
	irritable bowel syndro				
		for docusate sodium (used			
		100mg 1 capsule twice a			
	day.				
		for lamotrigine (used to treat			
		g 1 tablet twice a day.			
		for hydroxyzine 50mg 1			
	capsule three times a	oay. for midodrine (used to treat			
		on) 10mg 1 tablet three			
	times a day.				
		for sertraline (used to treat			
	depression) 100mg 1				
		for melatonin (used to treat			
	insomia) 5mg 2 capsu				
		for zinc (used to supplement			
	zinc levels) 50mg 1 ta				
		for aspirin (used to prevent			
	blood clots) EC 81mg				
	high cholesterol) 10m	for simvastatin (used to treat			
	-	_			
		for albuterol sulfate (used to gm 2 puffs up to 4 times a			
	day.	giii z puiis up to 4 tillies a			
		for symbicort (used to treat			
		is. Symbiosit (assa to troat	1	I .	1

Division of Health Service Regulation

COPD) 160-4.5mcg 2 puffs two times a day.

STATE FORM 8899 3S8011 If continuation sheet 29 of 42

PRINTED: 04/26/2021 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
LISA'S FA	AMILY CARE HOME # 1		REST LAKE ROAD F CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		
C 320	-There was an order treat irritable bowel s four times a day as n -There was an order COPD) 0.083% 1 via as neededThere was an order COPD) 18mcg inhale -There was an order pain) 10mg 1 tablet to the result of	for dicyclomine (used to yndrome) 10mg 1 capsule eeded. for albuterol (used to treat I via nebulizer every 8 hours for spiriva (used to treat a 1 capsule every day. for baclofen (used to treat three times a day as needed. for second revealed: ated 11/01/19. rovider (PCP) had not the review of medications ed 11/01/19 and the FL2 for the first available for the firs	C 320			

Division of Health Service Regulation

STATE FORM STATE FORM If continuation sheet 30 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL081054	B. WING		04	/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	•	
LICAICEA	MILV CADE HOME # 4		REST LAKE ROAD			
LISA'S FA	MILY CARE HOME # 1	FOREST	CITY, NC 28043			
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 320	Continued From page	30	C 320			
	(PCP) at least every s	six months.				
	04/13/21 at 2:20pm re -He did not know all re standing orders were the PCP at least ever -The PCP had been of months and would ha	esident medications and supposed to be reviewed by				
C 342	10A NCAC 13G .1004 Administration	4(j) Medication	C 342			
	(j) The resident's mer record (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa medication administer (4) instructions for ador treatment; (5) reason or justificat medications or treatmed documenting the resure (6) date and time of a (7) documentation of medications or treatment omission, including reference (8) name or initials of the medication or treatsignature equivalent to follow the signature equivalent to follow the signature of the medication of the signature equivalent to follow the signature equivalent to follow the signature equivalent to follow the medication of the signature equivalent to follow the medication of the signature equivalent to follow the si	red; ministering the medication tion for the administration of tents as needed (PRN) and alting effect on the resident; dministration; any omission of tents and the reason for the affusals; and the person administering the person administering the person initials are used, a to those initials is to be intained with the medication				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 31 of 42

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL081054 B. WING			04/	14/2021		
NAME OF PROVIDER OR SUPP	IER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	·		
LISA'S FAMILY CARE HOM	E#1		ST LAKE ROAI				
PREFIX (EACH DI	FICIENCY M	EMENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
Based on obsinterviews, the accuracy of m (MARs) for 1 of #3). The findings at Review of Res 02/10/21 reversing purple of the patitis C, m syndrome, and There was at 10mg 1 tablet 8:00am, 12:00 of There was at 10mg 1 tablet 8:00am, 12:00 of The CSCS for documented at 4:00pm, and 8 of the patitis C of the cSCS for t	ot met as ervations, facility	evidenced by: record reviews, and illed to ensure the administration records led residents (Resident securrent FL2 dated mentia, chronic disease (COPD), asthma, der, irritable bowel sophageal reflux disease. oxycodone (used to treat times a day. se Medication MAR) dated 02/08/21 to substance count sheets en entry for oxycodone se a day scheduled at om, and 8:00pm. ion oxycodone 10mg was 3/21 to 03/07/21 at om, and 8:00pm daily. ione 10mg was out at 8:00am, 12:00pm, om 02/08/21 to 03/07/21. se MAR dated 03/08/21 to realed: oxycodone on the MAR. intation of administration of 21 to 04/07/21.	C 342				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 32 of 42 3S8011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		FCL081054	B. WING		04	4/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	•	
	MILV OARE HOME #4	542 FOF	REST LAKE ROAD			
LISA'S FA	MILY CARE HOME # 1	FOREST	CITY, NC 28043			
(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 ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From pag	e 32	C 342			
	05/04/21 and CSCS -There was a handw 10mg 1 tablet four tir 8:00am, 12:00pm, 4: -There was documer administered from 04 04/13/21 at 8:00am, 8:00pm dailyThe CSCS for oxyco documented as signed 4:00pm, and 8:00pm 12:00pm. Observation of Residency oxycodone 10mg table revealed there were Interview with Residency revealed: -He went to a local p medications to help in -He currently took ox day for back painHe had never misses Interview with the Su 04/14/21 at 11:00am -He and the Manage administration of oxy 04/07/21 on the MAF	ritten entry for oxycodone mes a day scheduled at 00pm, and 8:00pm. Intation oxycodone 10mg was 4/05/21 at 8:00pm to 12:00pm, 4:00pm, and odone 10mg was ed out at 8:00am, 12:00pm, from 04/05/21 to 04/14/21 at 12:00pm ain clinic monthly for manage his back pain. Cycodone 10mg four times a ed a dose of his oxycodone. In the final field to document the codone from 03/08/21 to R, however the open documented on				
C 367	10A NCAC 13G .100	8(a) Controlled Substances	C 367			
		8 Controlled Substances me shall assure a readily				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 33 of 42

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			^-				
		FCL081054	B. WING		04	/14/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ΓE, ZIP CODE			
LISA'S FA	MILY CARE HOME # 1		EST LAKE ROAD				
	Т		CITY, NC 28043				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 367	Continued From page	e 33	C 367				
	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. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure the retrievable record of controlled substances were maintained and reconciled accurately for 2 of 3 sampled residents with the administration of pain medication (Residents #1 and #3) and anxiety medication (Resident #1).						
	The findings are:						
	Review of Resident #3's current FL2 dated 02/10/21 revealed: Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), asthma, hepatitis C, mood disorder, irritable bowel syndrome, and gastroesophageal reflux disease. There was an order for oxycodone (used to treat pain) 10mg 1 tablet four times a day.						
	O4/14/21 at 9:54am re- On 01/27/21, they re- Resident #3 for oxyco hours as needed for p -They dispensed 120 tablets for Resident # -On 02/24/21, they re- Resident #3 for oxyco hours as needed for p	ceived a prescription for odone 10mg 1 tablet every 6 pain. tablets of oxycodone 10mg 3 on 01/27/21. ceived a prescription for odone 10mg 1 tablet every 6 pain. tablets of oxycodone 10mg					

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 34 of 42 3S8011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL081054	B. WING		04	1/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
LISA'S FA	AMILY CARE HOME # 1		EST LAKE ROAD CITY, NC 28043			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 367	Resident #3 for oxyco hours as needed for partial tablets for Resident #4 Administration Recor 03/07/21 and controll (CSCS) revealed: -There was a handwr 10mg 1 tablet four tin 8:00am, 12:00pm, 4:00am, 12:00pm, 4:00am, 12:00pm, 4:00am, 12:00pm, 4:00am, 12:00pm, 10mg revealed there 120 on 01/30/21 and at 8:00am, 12:00pm, 01/30/21 to 03/02/21 quantity of zero. Review of Resident #04/07/21 and CSCS partial tablets and CSCS partial tablets and country for the control of the country for the control of the country for the cou	eceived a prescription for odone 10mg 1 tablet every 6 pain. I tablets of oxycodone 10mg 3 on 03/24/21. Italian Medication d (MAR) dated 02/08/21 to ed substance count sheets witten entry for oxycodone nes a day scheduled at 00pm, and 8:00pm. Itation oxycodone 10mg was 1/08/21 to 03/07/21 at 00pm, and 8:00pm daily. Italian oxycodone was a beginning quantity of documented as signed out 4:00pm, and 8:00pm from at 4:00pm with a remaining at 4:00pm with a remaining tasks.	C 367			
	90 on 03/02/21 at 4:0 signed out at 8:00am 8:00pm from 03/02/2 12:00pm with a rema	was a beginning quantity of 30pm and documented as 1, 12:00pm, 4:00pm, and 1 at 4:00pm to 03/24/21 at ining quantity of zero. 43's MAR dated 04/05/21 to revealed:				
	-There was a handwr	ritten entry for oxycodone nes a day scheduled at				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 35 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
	FCL081054 B.		B. WING	B. WING		4/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		ST LAKE ROAI ITY, NC 28043			
	CLIMMADY CT				ION	0.5
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 367	Continued From page	e 35	C 367			
C 307	-There was documen administered from 04 04/13/21 at 8:00am, 8:00pm dailyReview of Resident 10mg revealed there 120 on 03/24/21 at 4: signed out at 8:00am 8:00pm from 03/24/212:00pm with a remalereview of Resident 15 facility failed to document oxycodone 10mg on 0 at 8:00pm, and 04/14 Observation of Resident 15 of	tation oxycodone 10mg was /05/21 at 8:00pm to 12:00pm, 4:00pm, and #3's CSCS for oxycodone was a beginning quantity of 00pm and documented as , 12:00pm, 4:00pm, and 1 at 4:00pm to 04/13/21 at ining quantity of 40. #3's CSCS revealed the nent the administrations of 04/13/21 4:00pm, 04/13/21 //21 at 8:00am.	C 307			
	Interview with Resident #3 on 04/14/21 at 2:00pm revealed: -He went to a local pain clinic monthly for medications to help manage his back painHe currently took oxycodone 10mg four times a day for back painHe had never missed a dose of his oxycodone"I would know if I was not getting it." Interview with the Supervisor-In-Charge (SIC) on 04/14/21 at 11:00am revealed the Manager and SIC had failed to document the doses of oxycodone administered to Resident #3 on 04/13/21 4:00pm, 04/13/21 at 8:00pm, and 04/14/21 at 8:00am on the CSCS.					
	03/23/21 revealed: -Diagnoses included	t #1's current FL2 dated depressive disorder, diabetic chronic kidney disease and				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 36 of 42

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '		COMPLETED	
		FCL081054	B. WING		04/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		542 FOR	EST LAKE ROAI	D	
LISA'S FA	MILY CARE HOME # 1	FOREST	CITY, NC 28043	3	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 367	Continued From page	e 36	C 367		
	urinary retentionThere was an order t	for oxycodone-APAP (used			
		ng four times a day as			
	needed.	ig rour innee a day do			
	-There was an order t	for clonazepam (used to			
	treat anxiety) 0.5mg f	our times a day.			
	a Daview of Daviden	t #415 Madiantian			
	a. Review of Residen	d (MAR) dated 03/08/21			
	through 04/04/21 reve				
	_	oxycodone 10/325mg four			
	_	mented as administered 4			
	times a day from 03/0	08/21 through 04/04/21.			
	Davious of Davidant #	1'a MAD datad 04/05/21			
	through 05/04/21 reve	1's MAR dated 04/05/21			
	_	oxycodone 10/325mg four			
	_	mented as administered 4			
	1	05/21 through 04/13/21.			
	Observation of Reside	ent #1's available			
	_	325mg on 04/13/21 at			
	3:55pm revealed ther	e were 60 tablets available.			
	Review of Resident #	1's Control Substance			
	Count Sheet (CSCS)	•			
	10/325mg revealed:	•			
	-There was a beginni	ng quantity of 5 on 03/28/21			
		120 added on 03/29/21 and			
	_	d out at 8:00am, 12:00pm,			
		from 03/28/21 at 8:00am to			
	04/13/21 at 12:00pm 58.	with a remaining quantity of			
		on 04/04/21 at 12:00pm			
		lance of 96 pills was carried			
	T	and documented as 95			
	pills.				
	T-1	otale Description (114)			
	Telephone interview v	with Resident #1's er at the pain clinic on			

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 37 of 42

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER B. WING D4/14/	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 542 FOREST LAKE ROAD FOREST CITY, NC 28043 (X4) ID PROVIDER'S PLAN OF CORRECTION	בט	
SUBMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REPRENCED TO THE APPROPRIATE C 367 Continued From page 37 C 367 C 367 O4/14/21 at 10:51am revealed Resident #1 had an order for oxycodone-APAP 10/325mg written 02/11/21, 02/25/21 and 03/25/21 and could receive it four times a day. Interview with the Supervisor in Charge (SIC) on 04/13/21 at 3:55pm revealed he did not know why the CSCS showed less pills than were actually available. b. Review of Resident #1's Medication Administration Record (MAR) dated 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 03/08/21 through 04/04/21. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 04/05/21 through 04/12/21 and on 04/13/21 at 8:00am. Observation of Resident #1's clonazepam 0.5mg on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other	/2021	
(24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 367 C Ontinued From page 37 O4/14/21 at 10:51am revealed Resident #1 had an order for oxycodone-APAP 10/325mg written 02/11/21, 02/25/21 and 03/25/21 and could receive it four times a day. Interview with the Supervisor in Charge (SIC) on 04/13/21 at 3:55pm revealed he did not know why the CSCS showed less pills than were actually available. b. Review of Resident #1's Medication Administration Record (MAR) dated 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 04/05/21 through 04/04/21 and on 04/13/21 at 8:00am. Observation of Resident #1's clonazepam 0.5mg on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other		
CAMPINE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C 367 Continued From page 37 C 367		
C 367 Continued From page 37 C 367		
04/14/21 at 10:51am revealed Resident #1 had an order for oxycodone-APAP 10/325mg written 02/11/21, 02/25/21 and 03/25/21 and could receive it four times a day. Interview with the Supervisor in Charge (SIC) on 04/13/21 at 3:55pm revealed he did not know why the CSCS showed less pills than were actually available. b. Review of Resident #1's Medication Administration Record (MAR) dated 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 03/08/21 through 04/04/21. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 04/05/21 through 04/04/21 and on 04/13/21 at 8:00am. Observation of Resident #1's clonazepam 0.5mg on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other	(X5) COMPLETE DATE	
an order for oxycodone-APAP 10/325mg written 02/11/21, 02/25/21 and 03/25/21 and could receive it four times a day. Interview with the Supervisor in Charge (SIC) on 04/13/21 at 3:55pm revealed he did not know why the CSCS showed less pills than were actually available. b. Review of Resident #1's Medication Administration Record (MAR) dated 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 03/08/21 through 04/04/21. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 04/05/21 through 04/12/21 and on 04/13/21 at 8:00am. Observation of Resident #1's clonazepam 0.5mg on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other		
the CSCS showed less pills than were actually available. b. Review of Resident #1's Medication Administration Record (MAR) dated 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 03/08/21 through 04/04/21. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 04/05/21 through 04/12/21 and on 04/13/21 at 8:00am. Observation of Resident #1's clonazepam 0.5mg on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other		
Administration Record (MAR) dated 03/08/21 through 04/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 03/08/21 through 04/04/21. Review of Resident #1's MAR dated 04/05/21 through 05/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 04/05/21 through 04/12/21 and on 04/13/21 at 8:00am. Observation of Resident #1's clonazepam 0.5mg on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other		
through 05/04/21 revealed there was an entry for clonazepam 0.5mg four times a day and documented as administered 4 times a day from 04/05/21 through 04/12/21 and on 04/13/21 at 8:00am. Observation of Resident #1's clonazepam 0.5mg on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other		
on 04/13/21 at 3:55pm revealed resident #1's clonazepam 0.5mg was packaged with his other		
Review of Resident #1's CSCS revealed a CSCS was not available for clonazepam 0.5mg.		
Interview with a pharmacist at the facility's contracted pharmacy on 04/14/21 at 9:09am revealed: -The clonazepam 0.5mg was packaged in Resident #1's roll of sealed multi-pack medications. -They did not provide CSCS for clonazepam 0.5mg because they did not know they needed to		

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 38 of 42

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND FLAN	AND PLAN OF CORRECTION IDENTIFICATION NOWIBER.		A. BUILDING: _	COMPLETED	
		FCL081054	B. WING		04/14/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LISA'S FA	MILY CARE HOME # 1		T LAKE ROAL		
			ITY, NC 28043		
(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 APPROPE DEFICIENCY)	BE COMPLETE
C 367	Continued From page	38	C 367		
	provide one for medica multi-packThe facility had not related in the support of the support o	eations that were included in equested a CSCS. Dervisor in Charge (SIC) on revealed he did not know			
C 612	10A NCAC 13G .170 ² Control Program (terr	1 (c) Infection Prevention & p)	C 612		
	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 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 Based on observation reviews the facility fai	ns, interviews, and record			

Division of Health Service Regulation

STATE FORM 9899 3S8011 If continuation sheet 39 of 42

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL081054	B. WING		04	1/14/2021	
	ROVIDER OR SUPPLIER	542 FOR	DDRESS, CITY, STATE EST LAKE ROAD CITY, NC 28043	, ZIP CODE			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 612	recommendations and for Disease Control (Department of Health (NCDHHS) were impresidents during the gresidents during the gresidents, staff, and The findings are: Review of the CDC grand spread of COVID facilities last updated and spread of COVID facilities last updated and essential visitors presence of fever and when entering the burden entering the burden entering the burden entering the burden entering the NCDH prevention and spread facilities dated 09/2020 and respiratory. Review of the NCDH prevention and spread facilities dated 09/2020 and respiratory. All visitors to the facility signs and symptoms entering the facility. Observation upon en 04/13/21 at 9:20am respiratory at 120 am res	d guidance by the Centers CDC) and the North Carolina and Human Services demented when caring for 6 global Coronavirus ic as related to the screening divisitors. Duidelines for the prevention of 1/20/20 revealed: should be screened for the disymptoms of the virus diding. The screened for fever and 1/20 before starting each dily for fever and symptoms of the did of COVID-19 in LTC 20 revealed: esidents at least daily for symptoms. dility should be screened for the did of COVID-19 prior to trance into the facility on evealed: bunted infrared thermometer and log hanging below the mot screened for COVID-19 neck or asked screening	C 612				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 40 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL081054 B. WING 04		04/14/2	/14/2021		
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 0-7/1-7/2	<u> </u>
I ICA'C EA	MILY CARE HOME # 1		T LAKE ROAI			
LISA S FA	WILT CARE HOWE # 1	FOREST C	ITY, NC 28043	1		
(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 APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
C 612	Continued From page	e 40	C 612			
	temperature check will-Residents were scretemperature checkHe did not screen the was shocked and tore-He requested the suidiscovery of his mistal Interview with the Sup 04/13/21 at 9:35 reverse -He received some in from NCDHHSThe facility followed sunderstood"He did not think he as information NCDHHS-He and the manager-Four of the six reside been vaccinatedThe 2 unvaccinated vaccine and the 1 unvaccine and the 1 unvaccine and the 1 unvaccine and the six reside been vaccine and the 1 unvaccine and the 2 unvaccine and the 2 unvaccine and the 1 unvaccine and the 1 unvaccine and the 2 unvaccine and the 3 unvacc	ed for COVID-19 with a men they entered the facility. ened every other day with a se surveyors because "he e up" when they arrived. reveyor be screened upon alke. Dervisor-in-Charge (SIC) on aled: formation about COVID-19 The guidance "the best we lways received all the had sent out. lived at the facility. ents and 1 of the 2 staff had residents had refused the vaccinated staff was unable all reasons. The entered was unable and residents on 04/13/21 at 9:30 am a sist temperature every day. The entered is the properties of the control of				
	9:52am revealed his tevery other day.	emperature was checked				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 41 of 42

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL081054 B. WING 04/14				4/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LISA'S FA	MILY CARE HOME # 1		ST LAKE ROAI ITY, NC 28043			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 612	Continued From page	2 41	C 612			
	9:57am revealed: -Staff did not check h -Staff did not screen h COVID-19 every day. Interview with the SIC revealed: -The facility had not be since the beginning of they screened themse temperatures on the partnersHe never asked heal because he knew the before they reported the sident temperaturesHe and the manager resident temperaturesHe went on the state information because he information from NCD and COVID-19. Interview with the manalo:35am revealed: -He, the SIC and the anywhere except to non-He did not keep a log temperaturesHe had a visitor screed currently hanging but the hung the current	con 04/14/21 at 8:12am been allowing visitors inside if the pandemic. by orders came to the facility elves and logged their baper under the atthcare providers questions by had to screen themselves				

Division of Health Service Regulation

STATE FORM 8899 3S8011 If continuation sheet 42 of 42