STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 and the Edgecombe County Department of Social Services conducted an annual survey, a follow-up survey and complaint investigations on November 22, 2022. The complaint investigations were initiated by the Edgecombe County Department of Social Services on November 10, 2022.	C 000		
C 079	10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (6) have supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This rule apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide the residents with soap, hand towels, toilet paper, and bed sheets. The findings are: Observation of the resident's bathroom on 11/22/22 at 7:31am revealed: -There was no toilet paper in the bathroom. -There were no paper towels or hand towels in the bathroom. -There was an empty bottle of hand sanitizer on the sink. Observation of a resident's bedroom on 11/22/22 at 6:46am revealed: -There were no sheets on the resident's bed and	C 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 079	Continued From page 1	C 079		

the mattress was exposed.
-The resident had two blankets on her bed.

Interview with a resident on 11/22/22 at 6:46am revealed:
-The residents were given one roll of toilet paper a week to use.
-The residents were to take the roll of toilet paper with them to the bathroom and take it back to their room when they were finished.
-There was no soap in the bathroom for them to wash their hands.
-She had hand sanitizer in her room that she purchased.

A second interview a resident on 11/22/22 at 3:30pm revealed:
-The residents washed their laundry on Saturdays.
-She did not have clean sheets on her bed because she vomited from coughing over the weekend and had not washed them yet.

Telephone interview with a resident's Crisis Coordinator on 11/09/22 at 9:50am revealed the residents were given one roll of toilet paper weekly.

Interview with the medication aide (MA) on 11/22/22 at 7:30am revealed:
-Residents were given one roll of toilet paper weekly to take with them to the bathroom.
-One roll should last them a whole week.
-There was hand sanitizer by the medication cart for the residents to use.

Interview with the Administrator on 11/22/22 at 2:23pm revealed:
-Resident sheets were changed every Saturday.
-If a resident was missing sheets he would expect

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 079	Continued From page 2 the resident to let him know. -Residents were provided one roll of toilet paper a week. -One resident was always requesting more toilet paper. -He was not sure if it was because she was female but he could not understand why she needed more toilet paper than the other 4 male residents. -He did not allow toilet paper to be left in the bathroom because it was rationed out to the residents weekly. -The residents could use hand sanitizer that was in the living room on the medication cart because they have had a resident in the past that drank the bathroom soap. Telephone interview with the facility's contracted primary care provider (PCP) on 11/22/22 at revealed: -She expected the residents to have toilet paper available next to the commode in the bathroom. -She expected the residents to have soap available at the bathroom sink to wash their hands to prevent spread of infection and bacteria. -She expected the residents to have towels available to dry their hands in the bathroom. -She expected residents to have basic necessities including toilet paper, soap, paper towels and bed linens available to them at all times.	C 079		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical,	C 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 102	Continued From page 3 mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that the plumbing was in working order for 1 of 1 resident's bathroom and that the fire alarm was in safe, working order. The findings are: 1. Observation of the resident's bathroom on 11/22/22 at 7:31am revealed: -The sink was full of water and the stopper on the sink was open. -There was water and feces sitting in the toilet. -The water and feces did not go down after toilet was flushed. Interview with the medication aide (MA) on 11/22/22 at 8:03am revealed: -He was not aware that the toilet and sink were clogged. -He would work on getting it fixed. Observation of a conversation between a resident and the MA on 11/22/22 at 12:20pm revealed: -The resident told the MA that the toilet was not flushing. -The MA went down the hallway to the bathroom and worked on trying to get the toilet to flush. Second observation of the resident's bathroom at 12:31pm revealed: -The sink was full of water and the stopper on the sink was open.	C 102		

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 102	Continued From page 4 -There was water and feces sitting in the toilet. -The water and feces did not go down after toilet was flushed. Interview with the Administrator on 11/22/22 at 12:35pm revealed: -He was surprised that the toilet was not working. -Residents could use the MA's bathroom if they needed to do so. -He thought the MA fixed the clogged toilet and sink already that day. -One of the residents must have flushed something down the toilet they were not supposed to because it was working properly before. Third observation of the resident's bathroom on 11/22/22 at 1:45pm revealed: -There was water and feces sitting in the toilet. -The water and feces did not go down after toilet was flushed. -The Administrator stated, "the toilet is fixed". -The Administrator walked into the bathroom to flush toilet. -The toilet did not flush after being flushed by the Administrator. Second interview with the Administrator on 11/22/22 at 2:22pm revealed: -He was responsible for ensuring that the facility's plumbing was operational and in working order. -He had plumbers come to the facility in April or May of 2022 to fix previous plumbing issues. -He was not aware that there were currently any plumbing issues. Telephone interview with the facility's contracted primary care provider (PCP) on 11/22/22 at 8:35am revealed: -She expected the resident's bathroom to have	C 102		

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 102	Continued From page 5	C 102		

plumbing in working order.
-It was important for plumbing to be operational in order to prevent spread of infection.
-Basic plumbing was a fundamental necessity for the residents.

2. Previous observation of the facility on 11/10/22 at 3:15pm by the county Adult Home Specialist revealed that the beeping was occurring during her visit to the facility.

Observation on the initial tour of the facility on 11/22/22 at 6:46am revealed there was a beeping noise audible from all rooms of the house approximately every 50 seconds.

Interview with the medication aide (MA) on 11/22/22 at 8:03am revealed:
-He did not know what the beeping noise was.
-He did not know how long the beeping noise had been going on.

Observation of the smoke detector in the main hallway on 11/22/22 at 2:23pm revealed:
-There was a loud beep coming from the smoke detector every 50 seconds.
-The smoke detector was located in the hallway outside 3 resident rooms and the resident's common bathroom.
-The loud beep could be heard throughout the facility.

Interview with a resident on 11/22/22 at 3:30pm revealed:
-The beeping noise had been happening for weeks.
-It was hard to sleep at night because of the beeping noise.

Interview with the Administrator on 11/22/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 102	Continued From page 6 3:02pm revealed: -He was not aware that it was the smoke detector in the main hallway that was beeping. -He thought the beeping was coming from a security system that had been installed by the previous facility owner. -He had recently replaced the battery in the smoke detector in the main hallway but the beeping continued.	C 102		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that water temperatures were maintained at 100 to 116 degrees Fahrenheit (F) for 2 of 2 fixtures including the sink in the resident's bathroom and the kitchen sink with water temperature ranges from 119-121 degrees F. The findings are: Observation of the kitchen sink on 11/22/2022 at 7:11am revealed: -The water temperature was 121 degrees Fahrenheit (F). -There was no visible steam from the water	C 105		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 105	Continued From page 7	C 105		

stream.

Observation of the kitchen sink on 11/22/22 at 9:30am revealed a resident was washing their breakfast dish.

A second observation of the kitchen sink on 11/22/22 at 2:00pm with the Administrator revealed:
-The Administrator was at the sink while the surveyor checked the water temperature.
-The water temperature was 119 degrees F.
-There was no visible steam from the water stream.

Observation of the resident's bathroom on 11/22/2022 at 8:10am revealed:
-The water temperature was 120 degrees F.
-There was no visible stream from the water stream.

Interview with a resident on 11/22/22 at 3:30pm revealed the water was not too hot to use in the bathroom.

Interview with the Administrator on 11/22/22 at 2:20pm revealed:
-He was responsible for ensuring water temperature ranges were between 100 to 116 degrees F.
-There was one bathroom for the residents to use.
-He checked water temperatures monthly but did not document them.
-He could not recall the last time he checked the water temperatures at the facility.
-He could not locate his thermometer.
-There were no complaints that he was aware of from the residents about the water being too hot.
-He was not at aware of any residents being

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 105	Continued From page 8 burned from hot water.	C 105		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) who was administering medications had completed the medication skills validation checklist prior to administering medications. The findings are: Observation of the morning medication administration on 11/22/22 at 7:30am and 8:45am revealed Staff A administered medications to the residents. Review of October 2022 and November 2022	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 131	Continued From page 9	C 131		

medication administration records (MAR) revealed Staff A administered medications independently to the residents starting 10/03/22.

Review of Staff A's, medication aide (MA), personnel record revealed:
-Staff A had a hire date of 10/01/22.
-There was no documentation of a medication clinical skills checklist for Staff A.
-There was no documentation Staff A had taken and passed the medication aide exam.
-Staff A completed the 15-hour medication aide training on 08/15/22.

Interview with Staff A on 11/22/22 at 2:00pm revealed:
-He started working at the facility on 10/01/22.
-He was responsible for administering the resident's daily medications.

Interview with a resident on 11/22/22 at 3:30pm revealed Staff A administered the resident's medications.

Interview with the Administrator on 11/22/22 at 2:20pm revealed:
-He was not aware that all MAs working at the facility were required to complete the medication aide clinical skills checklist.
-Staff A had not been signed off on the medication aide clinical skills checklist.
-He thought that because he had taken the state MA test that Staff A was not required to complete the MA clinical skills checklist or take the state test.
-He was in the process of trying to hire a nurse to complete the training for Staff A.

Telephone interview with the facility's contracted mental health provider (MHP) on 11/22/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 131	Continued From page 10 1:52pm revealed: -At a previous visit to the facility she observed Staff A at the medication cart. -Staff A documented on a resident's MAR that he had administered a medication that the resident did not have on hand. -It appeared that Staff A was just going through the resident's MAR and initialing that he had administered medications without making sure that the medications were actually administered. -Some residents at the facility had serious psychiatric histories so it was important that the staff administering their medications were well trained to administer the medications correctly so that they did not have adverse affects from not receiving their medications as ordered. Refer to Tag C 330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation). Refer to Tag C 341 10A NCAC 13G .1004(i) Medication Administration. Refer to Tag C 342 10A NCAC 13G .1004(j) Medication Administration. Refer to Tag C 346 10A NCAC 13G .1004(n) Medication Administration. Refer to Tag C 353 10A NCAC 13G .1006(b) Medication Storage. Refer to Tag C 367 10A NCAC 13G .1008(a) Controlled Substances. _____ The facility failed to ensure Staff A, a medication aide, completed the medication skills checklist and passed the medication aide exam. The facility's failure to ensure Staff A was properly trained prior to administering medications	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 131	Continued From page 11 independently was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 11/22/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 6, 2022.	C 131		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) was verified through the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff A, medication aide (MA) personnel file on 11/22/22 revealed: -Staff A was hired 10/01/22. -There was no documentation of a Health Care Personnel Registry (HCPR) check upon hire. -Staff A had a HCPR check on 11/08/22. Interview with Staff A on 11/22/22 at 2:00pm	C 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 145	Continued From page 12 revealed he started at the facility on 10/01/22. Interview with the Administrator on 11/22/22 at 2:20pm revealed: -He was responsible for ensuring that a HCPR check was run on employees upon hire. -He was not sure why Staff A's HCPR was not checked until 11/08/22. -He was not sure what prompted him to complete a HCPR on 11/08/22.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of Staff A, medication aide (MA) personnel file on 11/22/22 revealed: -Staff A was hired 10/01/22. -There was no documentation of a criminal background check completed upon hire. -Staff A had a criminal background check completed on 11/08/22. Interview with Staff A on 11/22/22 at 2:00pm	C 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 147	Continued From page 13 revealed he started at the facility on 10/01/22. Interview with the Administrator on 11/22/22 at 2:20pm revealed: -He was responsible for ensuring that a criminal background check was completed on employees upon hire. -He was not sure why Staff A's criminal background check was not completed until 11/08/22. -He was not sure what prompted him to complete a criminal background check on 11/08/22.	C 147		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) was competency validated for Licensed Health Professional Support (LHPS) tasks by return demonstration including obtaining fingerstick blood sugar checks prior to performing these tasks on a diabetic resident (#2). The findings are:	C 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 171	Continued From page 14 Review of Staff A, medication aide (MA) personnel file on 11/22/22 revealed: -Staff A was hired 10/01/22. -There was no documentation of a Licensed Health Professional Support (LHPS) tasks checklist being completed. Interview with Staff A on 11/22/22 at 2:00pm revealed he started at the facility on 10/01/22. Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included type 2 diabetes. Review of Resident #2's physician order sheet dated 05/09/22 revealed there was an order to start fingerstick blood sugar (FSBS) checks twice daily before breakfast and before dinner. Review of Resident #2's October 2022 MAR revealed: -There was an entry for check FSBS before breakfast daily scheduled at 8:00am. -There was no entry to check FSBS before dinner. -FSBS was documented as performed by Staff A at 8:00am 10/01/22 to 10/31/22. Interview with Staff A on 11/22/22 at 9:05am revealed he performed FSBSs on Resident #2 from time to time. Interview with the Administrator on 11/22/22 at 2:20pm revealed: -He was responsible for ensuring that a LHPS task checklist was completed for staff performing FSBS. -He had not had a Registered Nurse (RN) working for him since February of 2021, so he did	C 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 171	Continued From page 15 not have a training nurse to sign off staff on LHPS skills. -He was in the process of trying to find a nurse to complete staff training.	C 171		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the Administrator was responsible for the total operation of the home, to meet and maintain the rules in areas of Qualifications of Medication Staff, Health Care, Medication Administration and Resident Rights. The findings are:	C 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 16 Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 5 ambulatory residents and a current census of 5 residents. Observation of the facility upon entrance on 11/22/22 at 6:38am revealed: -There was a medication aide (MA) working. -The Administrator was not on-site. -The MA called the Administrator to inform him of the survey. Interview with the MA on 11/22/22 at 7:30am revealed: -The Administrator was on his way to the facility. -He did not have access to the resident's records, only their medication administration records (MAR). -When the Administrator arrived, he would be able to give the surveyors access to the resident's records. Observation of the facility on 11/22/22 at 9:55am revealed the Administrator arrived at the facility and was able to provide the surveyors with access to the residents' records. Interview with a resident on 11/22/22 at 6:45am revealed: -The resident would ask the medication aide (MA) on duty for cough medication that the physician prescribed for them; and the MA said they would have wait until the Administrator came. -The Administrator was not at the building every day. -The Administrator had not been at the building in over 4 days. Interview with the Administrator on 11/22/22 at 2:20pm revealed:	C 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 17	C 185		

-He was responsible for the total operations of the facility.
-He was on-site at the facility every day.
-The MA "covers" for the Administrator when he was not on-site.
-In September of 2022 he received notice from the facility's contracted primary care provider (PCP) that their last day providing medical services to the facility would be 11/22/22.
-He reached out to another provider to see if they would be willing to accept the residents as patients and they had a first appointment in the middle of January 2023.
-He asked the current PCP to continuing covering resident's medical needs until January 2023 but had not received a response.

Telephone interview with the facility's contracted mental health provider (MHP) on 11/22/22 at 1:52pm revealed:
-At a previous visit to the facility she observed Staff A at the medication cart.
-Staff A documented on a resident's MAR that he had administered a medication that the resident did not have on hand.
-It appeared that Staff A was just going through the resident's MAR and initialing that he had administered medications without making sure that the medications were actually administered.
-Some residents at the facility had serious psychiatric histories so it was important that the staff administering their medications were well trained to administer the medications correctly so that they did not have adverse affects from not receiving their medications as ordered.

Non-compliance was identified in the following rule areas:

1. Based on interviews and record reviews, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 18 facility failed to ensure 1 of 2 sampled staff (Staff A) who was administering medications had completed the medication skills validation checklist prior to administering medications [Refer to Tag C0131 10A NCAC 13G .0403(a) Qualifications of Medication Staff (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure implementation of orders for 1 of 3 sampled residents (#2) for orders in which a resident was to have twice daily fingerstick blood sugars (FSBS). [Refer to Tag C0249 10A NCAC 13G .0902(c) Health Care (Type B Violation)]. 3. Based on observations and interviews, the facility failed to respond to reasonable requests related to a resident being denied to to take his medications with a beverage other than water, a resident not being provided additional pillows when requested and not addressing a constant audible beeping smoke detector that disturbed the resident's sleep at night; and the facility failed to treat a resident with respect by yelling at her when she requested additional toilet paper. [Refer to Tag C0311 10A NCAC 13G .0909 Resident Rights (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents sampled including antibiotics for a resident with bronchitis, not having multiple ordered medications available for administration for a resident with anxiety (#1) and a resident with multiple medical diagnoses including schizophrenia, diabetes, and high cholesterol (#2), and for a resident that did not have a medication administration record available to	C 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 19	C 185		

review (#3) [Refer to Tag C0330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].

5. Based on observations and interviews, the facility failed to provide the residents with soap, hand towels, toilet paper, and bed sheets [Refer to Tag C0079 10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings].

6. Based on observation and interviews, the facility failed to ensure that the plumbing was in working order for 1 of 1 resident's bathroom and that the fire alarm was in safe, working order [Refer to Tag C0102 10A NCAC 13G .0317(a) Building Service Equipment].

7. Based on observations and interviews, the facility failed to ensure that water temperatures were maintained at 100 to 116 degrees Fahrenheit (F) for 2 of 2 fixtures including the sink in the resident's bathroom and the kitchen sink with water temperature ranges from 119-121 degrees F [Refer to Tag C0105 10A NCAC 13G .0317(d) Building Service Equipment].

8. Based on record review and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) was verified through the North Carolina Health Care Personnel Registry (HCPR) upon hire [Refer to Tag C0145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications].

9. Based on record review and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had a criminal background check completed upon hire [Refer to Tag C0147 10A NCAC 13G .0406(a)(7) Other Staff Qualifications].

10. Based on interviews and record reviews, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 20	C 185		

facility failed to ensure 1 of 2 sampled staff (Staff A) was competency validated for Licensed Health Professional Support (LHPS) tasks by return demonstration including obtaining fingerstick blood sugar checks prior to performing these tasks on a diabetic resident (#2) [Refer to Tag C0171 10A NCAC 13G .0504(a) Competency Evaluation and Validation For Licensed Health Professional Support Tasks].

11. Based on record reviews and interviews, the facility failed to ensure 3 of 3 residents sampled (#1, #2, #3) had completed tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services [Refer to Tag C0202 10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination].

12. Based on record reviews and interviews, the facility failed to ensure 1 of 6 residents sampled (#1) had an annual FL-2 completed (#1) and had a FL-2 completed prior to admission (#6) [Refer to Tag C0203 10A NCAC 13G .0702(b) Tuberculosis Test and Medical Examination].

13. Based on interviews and record reviews, the facility failed to ensure that 2 of 3 residents sampled (#1, #2) had an annual care plan completed [Refer to Tag C0236 10A NCAC 13G .0802(a) Resident Care Plan].

14. Based on interviews and record reviews, the facility failed to ensure health care referral and follow up for 2 of 4 residents sampled related to a gynecologist appointment (#1) [Refer to Tag C0246 10A NCAC 13G .0902(b) Health Care].

15. Based on record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 21	C 185		

completed on 1 of 3 sampled residents (#2) to include the identified task of fingerstick blood sugars (FSBS) [Refer to Tag C0254 10A NCAC 13G .0903(c) Licensed Health Professional Support].

16. Based on observations, interviews, and record reviews, the facility failed to ensure medications administered were documented upon administration for 3 of 3 residents sampled (#1, #2, and #3) [Refer to Tag C0341 10A NCAC 13G .1004(i) Medication Administration].

17. Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were complete and accurate for 2 of 2 residents sampled (#1 and #2) [Refer to Tag C0342 10A NCAC 13G .1004(j) Medication Administration].

18. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered in accordance with infection control measures to prevent the development and transmission of disease or infection, prevent cross-contamination, and provide a safe and sanitary environment for staff and residents when administering 1 of 1 resident's morning medication (Resident #3) [Refer to Tag C0346 10A NCAC 13G .1004(n) Medication Administration].

19. Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 1 residents sampled (#5) that was self-administering their own insulin injections had an order to self administer from a prescribing practioner [Refer to Tag C0350 10A NCAC 13G .1005(a and b) Self-Administration of Medications].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 22 20. Based on observations and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration including controlled substances for 1 of 1 medication carts [Refer to Tag C0353 10A NCAC 13G .1006(b) Medication Storage]. 21. Based on record review and interview the facility failed to ensure that physician-prescribed medications were released with the resident upon discharge for 1 of 1 sampled resident (#6). [Refer to Tag C0361 10A NCAC 13G .1007(a) Medication Disposition]. 22. Based on observations, interviews, and record reviews, the facility failed to ensure controlled substance records for 1 of 1 sampled resident (#1) were accurately reconciled with the administration of a controlled substance used for anxiety [Refer to Tag C0367 10A NCAC 13G .1008(a) Controlled Substances]. 23. Based on record reviews and interviews, the facility failed to obtain the services of a licensed pharmacist, prescribing practitioner, or registered nurse for the provision of pharmaceutical care at least quarterly for 2 of 3 residents (#1, #2) residing in the facility [Refer to Tag C0375 10A NCAC 13G .1009(a)(1) Pharmaceutical Care]. _____ The Administrator failed to ensure that the management and operations of the facility were implemented to ensure services necessary to maintain the residents' physical and mental health were provided as evidenced by the failure to maintain compliance with the rules and statutes governing adult care homes, which is the	C 185		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 185	Continued From page 23 responsibility of the Administrator. This is detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility did not provide an acceptable plan of protection in accordance with G.S. 131D-34 on 11/22/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 6, 2022.	C 185		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 residents sampled (#1, #2, #3) had completed tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Health Services. The findings are: 1.Review of Resident #1's most recent FL-2 dated 03/31/21 revealed:	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 202	Continued From page 24 -Diagnoses included hyperlipidemia, epilepsy, and schizoaffective disorder. -Resident #1 was admitted to the facility on 12/08/20. Review of Resident #1's facility record revealed there was no Resident Register. Review of Resident #1's Tuberculosis (TB) Skin Test Record revealed: -She had a TB test placed 08/30/21. -She had her TB test read on 09/01/21 and there was 0mm result (negative). Review of Resident #1's facility record revealed there was no second step TB skin test completed. Refer to interview with the Administrator on 11/22/22 at 2:20pm. 2. Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included schizophrenia, type 2 diabetes, and hypertension. Review of Resident #2's Resident Register revealed he was admitted to the facility from another facility on 02/16/21. Review of Resident #2's record on revealed: -There was a Tuberculosis (TB) skin test administered at a primary care provider's (PCP) office on 02/06/17 and read as negative on 02/08/17. -There was no record of a TB skin test being done on admission for Resident #2. -There was no record of a second TB skin test being done for Resident #2 after 02/06/17. Refer to interview with the Administrator on	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 202	Continued From page 25 11/22/22 at 2:20pm. 3. Review of Resident #3's current FL-2 dated 10/26/22 revealed diagnoses included of hypertension, history of cerebrovascular accident, atrial fibrillation, and memory loss. Review of the Resident #3's Resident Register revealed he was admitted to the facility from a local hospital on 10/27/22. Review of Resident #3's record on 11/22/22 revealed there was a Tuberculosis (TB) skin test administered at a hospital that was read as negative but there was no date on the document. Refer to interview with the Administrator on 11/22/22 at 2:20pm. _____ Interview with the Administrator on 11/22/22 at 2:20pm revealed: -It was his responsibility to ensure that Tuberculosis (TB) tests were completed on the residents at admission. -He did not have a Registered Nurse working for him since February of 2021, so things such as the resident's TB tests had slipped by without him noticing.	C 202		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter.	C 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 203	Continued From page 26	C 203		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 1 of 6 residents sampled (#1) had an annual FL-2 completed (#1) and had a FL-2 completed prior to admission (#6).

The findings are:

Review of Resident #1's most recent FL-2 dated 03/31/21 revealed:
-Diagnoses included hyperlipidemia, epilepsy, and schizoaffective disorder.
-Resident #1 was admitted to the facility on 12/08/20.

Review of Resident #1's facility record revelaed there was not a more recent FL-2 than 03/31/21.

Interview with the Administrator on 11/22/22 at 2:20pm revealed:
-He was not aware that Resident #1 did not have a FL-2 completed within the last year.
-He was responsible for ensuring that FL-2s were completed annually on residents.
-He had not had a registered nurse working for him since February of 2021, so things such as the resident's annual FL-2 had slipped by without him noticing.

2. Review of Resident #6's facility file revealed there was no FL-2 on admission to the facility.

Telephone interview with Resident #6's Care Coordinator on 11/10/22 at 11:00am revealed:
-Resident #6 was admitted to the facility on 11/02/22 and left the facility on 11/04/22.
-Resident #6 did not have a FL-2 on arrival to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 203	Continued From page 27 -Resident #6 was admitted from a respite care facility and did not have a previous FL-2. Interview with the Administrator on 11/22/22 at 2:20pm revealed: -He asked Resident #6's Care Coordinator for a FL-2 when the resident was admitted. -He never received a FL-2 for Resident #6. -Resident #6 was only at the facility for 2 or 3 days before she left to stay with a family member.	C 203		
C 236	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 residents sampled (#1, #2) had an annual care plan completed. The findings are: 1.Review of Resident #1's most recent FL-2 dated 03/31/21 revealed: -Diagnoses included hyperlipidemia, epilepsy, and schizoaffective disorder. -Resident #1 was admitted to the facility on 12/08/20. Review of Resident #1's facility record revealed there was no Resident Register.	C 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 236	Continued From page 28 Review of Resident #1's care plan on 11/22/22 revealed: -The most recent care plan was completed by the Administrator on 03/31/21. -The activities of daily living was not completed on the care plan for Resident #1. Refer to interview with the Administrator on 11/22/22 at 2:20pm. 2. Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included schizophrenia, type 2 diabetes, and hypertension. Review of Resident #2's Resident Register revealed he was admitted to the facility 02/16/21. Review of Resident #2's record revealed: -The most recent care plan completed for Resident #2 was on 02/16/21. -The activities of daily living was not completed on the care plan for Resident #2. Refer to interview with the Administrator on 11/22/22 at 2:20pm. _____ Interview with the Administrator on 11/22/22 at 2:20pm revealed: -He was responsible for ensuring that residents had yearly care plans completed. -He was not aware that Resident #1 and Resident #2 did not have an annual care plan completed. -He had not had a Registered Nurse working for him since February of 2021, so things such as the resident's care plans had slipped by without him noticing.	C 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

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C 246	Continued From page 29	C 246		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 3 residents sampled related to a gynecologist appointment (#1). The findings are: Review of Resident #1's most recent FL-2 dated 03/21/21 revealed diagnoses included a communicable disease that is transmitted by exposure to blood and body fluids. Review of Resident #1's physician's orders dated 08/05/22 revealed there was an order for Resident #1 to be set up with a gynecologist appointment for annual screening. Interview with Resident #1 on 11/22/22 at 3:30pm revealed: -She had not been to the gynecologist for several years. -She was not currently experiencing any abdominal pain. Review of Resident #1's facility records on 11/22/22 revealed there were no records of a gynecologist appointment. Interview with the Administrator on 11/22/22 at 2:22pm revealed: -He did not remember if he made an appointment for Resident #1 to go to the gynecologist office as	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

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ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 246	Continued From page 30 ordered by Resident #1's primary care provider in August of 2022. -He expected the doctor's office to call and remind him of the appointments for residents. -He was responsible for ensuring that medical appointments were made for the residents. Telephone interview with Resident #1's PCP on 11/22/22 at 8:35am revealed: -She ordered a referral for Resident #1 to go to the gynecologist office for annual screening when she visited the facility in August of 2022. -It was the facility's responsibility to ensure that resident's appointments were made when ordered. -It was important for Resident #1 to have an appointment with the gynecologist because she was a woman and required annual screening. -Annual screening with a gynecologist was important for a woman for early detection of cervical disease. -Resident #1 not having a gynecologist appointment in a number of years placed her at risk for cervical disease and sexually transmitted diseases. -It was especially important for Resident #1 to be seen by a gynecologist because of her communicable disease diagnosis that is highly contagious and transmitted by blood and body fluids.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 249	Continued From page 31 (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure implementation of orders for 1 of 3 sampled residents (#2) for orders in which a resident was to have twice daily fingerstick blood sugars (FSBS). The findings are: Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included type 2 diabetes. Review of Resident #2's physician order sheet dated 05/09/22 revealed there was an order to start fingerstick blood sugar (FSBS) checks twice daily before breakfast and before dinner. Review of Resident #2's September 2022 medication administration record (MAR) revealed: -There was an entry for check FSBS before breakfast daily scheduled at 8:00am. -There was no entry to check FSBS before dinner. -FSBS was documented as performed at 8:00am on 09/01/22 and 09/02/22. -There were no FSBS values recorded 09/01/22 and 09/02/22. -FSBS was not documented as performed from 9/03/22 to 09/30/22. Review of Resident #2's October 2022 MAR	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 249	Continued From page 32	C 249		

revealed:
-There was an entry for check FSBS before breakfast daily scheduled at 8:00am.
-There was no entry to check FSBS before dinner.
-FSBS was documented as performed at 8:00am 10/01/22 to 10/31/22.
-There were no FSBS values recorded from 10/01/22 to 10/31/22.

Review of Resident #2's November 2022 MAR revealed:
-There was an entry for check FSBS before breakfast daily scheduled at 8:00am.
-There was no entry to check FSBS before dinner.
-FSBS was not documented as performed from 11/01/22 to 11/22/22.

Review of Resident #2's record revealed there were no FSBS values recorded anywhere in the record.

Review of Resident #2's laboratory sheet revealed:
-A Hemoglobin A1C was performed on Resident #2 on 08/15/22 (Hemoglobin A1C is a blood test which measures average blood sugar levels over the past 3 months).
-Resident #2's A1C was 7.5% on 08/15/22.
-The lab sheet stated, "For someone with known diabetes, a value greater than or equal to 7.0% indicates suboptimal control."

Observation of the medication cart on 11/22/22 at 9:40am revealed:
-There was a glucometer, blood sugar testing strips, and lancets on the medication cart.
-The glucometer or case was not labeled with Resident #2's name.

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 249	Continued From page 33 Interview with Resident #2 on 11/22/22 at 6:59am revealed he did not receive FSBSs anymore. Interview with the medication aide (MA) on 11/22/22 at 6:57am revealed: -Resident #2 was the only resident at the facility who received FSBS checks. -Resident #2 did not get his FSBS checks performed every day but only when it was suspected that he needed his FSBS performed. Second interview with the MA on 11/22/22 at 9:05am revealed: -He only performed FSBS checks on Resident #2 from time to time. -He did not know what prompted him to perform FSBSs on Resident #2 from time to time, but he performed them whenever he felt like they were needed. -If Resident #2 was receiving insulin it would be important for him to have FSBS checks performed before taking insulin but Resident #2 was not receiving insulin. -If FSBS checks were ordered to be performed every day then they should be performed every day. -He was not aware that Resident #2 had orders to receive FSBS checks twice a day. -When he performed FSBS checks on Resident #2 he did not document the FSBS checks anywhere but initialed on the MAR that the FSBS check was performed. -He knew Resident #2's FSBS checks were good because he checked them. -He did not know why he initialed that a FSBS was performed on Resident #2 everyday in October 2022 since he was not performing FSBSs on Resident #2 every day.	C 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 249	Continued From page 34 Interview with the Administrator on 11/22/22 at 2:34pm revealed: -Resident #2 used to receive daily FSBS checks but FSBS checks for Resident #2 were changed to weekly sometime earlier in 2022. -He did not know exactly when Resident #2's FSBS checks were decreased to weekly. -He was not aware there was an order from May 2022 for Resident #2 to receive FSBS checks twice a day. -Resident #2's FSBS values should be recorded when they were performed. -Since the MA initialed that FSBS checks were performed on Resident #2 every day in October then that meant they were performed every day. -Sometimes the MA might forget to record that he had performed a FSBS check on Resident #2. Interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am revealed: -She expected facility staff to perform FSBS checks twice a day for Resident #2 as ordered. -FSBS checks were needed to see blood sugar trends for Resident #2 and to see if his diabetes was under control. -There could be serious ramifications of not performing FSBS checks on Resident #2 as ordered such as causing sores or infection if his high blood sugars were not adequately treated. -Since FSBS checks were not being performed then she would not know if his FSBSs had been high or not. -It was important that FSBS checks were performed on Resident #2 as ordered because his oral diabetes medications might need to be adjusted depending on whether his FSBSs were too high or too low. -Resident #2 received Hemoglobin A1C lab tests at times to show overall diabetes control for the resident but it was important that she know what	C 249		

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 249	Continued From page 35 his FSBSs were trending like when she visited the resident so she could adjust his medications if needed. _____ The facility failed to ensure implementation of orders for 1 of 3 sampled residents (#2) including failing to perform twice a day fingerstick blood sugars (FSBS) that put the resident at risk of complications such as sores or infection from possible untreated high blood sugars. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility did not provide an acceptable plan of protection in accordance with G.S. 131D-34 on 11/22/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 6, 2022.	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 254	Continued From page 36	C 254		

tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 1 of 3 sampled residents (#2) to include the identified task of fingerstick blood sugars (FSBS).

The findings are:

Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included type 2 diabetes.

Review of Resident #2's physician order sheet dated 05/09/22 revealed there was an order to start blood sugar checks twice daily before breakfast and before dinner.

Review of Resident #2's record on 11/22/22 revealed there was no licensed health professional support (LHPS) evaluation.

Interview with the Administrator on 11/22/22 at 9:57am revealed Resident #2 received fingerstick blood sugars (FSBS).

Second interview with the Administrator on 11/22/22 at 12:19pm revealed previously there was a Registered Nurse who came to the facility

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 254	Continued From page 37 to complete LHPS evaluations, but there had not been a nurse at the facility since February 2021 and that was why there was no LHPS evaluation for Resident #2.	C 254		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to respond to reasonable requests related to a resident being denied to to take his medications with a beverage other than water, a resident not being provided additional pillows when requested and not addressing a constant audible beeping smoke detector that disturbed the resident's sleep at night; and the facility failed to treat a resident with respect by yelling at her when she requested additional toilet paper. The findings are: 1. Observation of the facility's living room on 11/22/22 at 7:10am revealed: -A resident came into the living room and asked the medication aide (MA) for a roll of toilet paper. -There were 4 people in the living. -The MA answered loudly that he had just given her a roll of toilet paper three days ago and asked her what she did with it. -The resident answered that she used it. -The MA yelled "I don't understand why you	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 311	Continued From page 38 always go through toilet paper so quickly!" -The MA went into his sleeping quarters and gave the resident a roll of toilet paper. Interview with the resident on 11/22/22 at 3:30pm revealed: -It made her embarrassed when the MA "punished her like a child" when she asked for more toilet paper. -The residents were given one roll of toilet paper a week to keep with them. -If they ran out of toilet paper, they could ask the MA for another but he would get mad. Observation of the resident on 11/22/22 at 3:30pm revealed the resident became tearful when discussing being yelled at by the MA in front of other people. Interview with the Administrator on 11/22/22 at 2:22pm revealed: -Residents were provided one roll of toilet paper a week. -One resident was always requesting more toilet paper. -He was not sure if it was because she was female but he could not understand why she needed more toilet paper than the other 4 male residents. -He did not allow toilet paper to be left in the bathroom because it was rationed out to the residents weekly. -He would work on training his MA to make sure residents did not feel embarrassed. 2. Observation of the living room on 11/22/22 at 8:10am revealed: -The medication aide (MA) called a resident up to the medication cart to receive a plastic cup of medications.	C 311		

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	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 311	Continued From page 39 -The resident had just finished breakfast and had his coffee cup in his hand. -The resident asked if he could take the medication with his coffee and the MA replied "no you must take it with water". -The MA then directed the resident to the kitchen sink to get himself a cup of water to take his medications with. Interview with the Administrator on 11/22/22 at 2:22pm revealed residents should be allowed to take their medications with a drink of their choice. 3. Telephone interview with a resident's Crisis Coordinator on 11/09/22 at 9:50am revealed: -The resident required having 3 extra pillows when using her continuous positive airway pressure (CPAP) machine. -The Administrator refused to give the resident extra pillows. Telephone interview with the resident #6 on 12/05/22 at 2:52 pm revealed: -The resident asked the Administrator for an extra pillow. -The Administrator told the resident he could not provide her with extra pillows. Interview with the Administrator on 11/22/22 at 2:22pm revealed: -Residents were allowed extra pillows if they were asked. -He did not remember Resident #6 asking for extra pillows. 4. Previous observation of the facility on 11/10/22 at 3:15pm by the county Adult Home Specialist revealed that the beeping was occurring during her visit to the facility.	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 311	Continued From page 40 Observation on the initial tour of the facility on 11/22/22 at 6:46am revealed there was a beeping noise audible from all rooms of the house approximately every 50 seconds. Interview with the medication aide (MA) on 11/22/22 at 8:03am revealed: -He did not know what the beeping noise was. -He did not know how long the beeping noise had been going on. Observation of the smoke detector in the main hallway on 11/22/22 at 2:23pm revealed: -There was a loud beep coming from the smoke detector every 50 seconds. -The smoke detector was located in the hallway outside 3 resident rooms and the resident's common bathroom. -The loud beep could be heard throughout the facility. Interview with a resident on 11/22/22 at 3:30pm revealed: -The beeping noise was happening for weeks. -It was hard to sleep at night because of the beeping noise. Interview with the Administrator on 11/22/22 at 3:02pm revealed: -He was not aware that it was the smoke detector in the main hallway that was beeping. -He thought the beeping was coming from a security system that had been installed by the previous facility owner. -He had recently replaced the battery in the smoke detector in the main hallway but the beeping continued. _____ The facility failed to ensure that resident's rights were protected by failing to meet reasonable	C 311		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 311	Continued From page 41 requests made by the residents such as extra pillows or allowing residents to take their medications with a beverage of their choice. The facility failed to treat residents with respect by embarrassing a resident in front of a group of people when asking for more toilet paper to which the resident became tearful. The facility did not address the beeping noise from the smoke detector that disrupted residents and prohibited them from sleeping at night. This is detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility did not provide an acceptable plan of protection in accordance with G.S. 131D-34 on 11/22/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 6, 2022.	C 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 42 Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 residents sampled including antibiotics for a resident with bronchitis, not having multiple ordered medications available for administration for a resident with anxiety (#1) and a resident with multiple medical diagnoses including schizophrenia, diabetes, and high cholesterol (#2), and for a resident that did not have a medication administration record available to review (#3). The findings are: 1.Review of Resident #1's most recent FL-2 dated 03/31/21 revealed diagnoses included hyperlipidemia, epilepsy, and schizoaffective disorder. a. Review of Resident #1's primary care provider (PCP) visit note dated 11/18/22 revealed: -Resident #1 was being seen for chronic management of her health conditions. -Resident #1 complained of some heartburn, a sore throat and productive cough. -She would prescribe Resident #1 medications to treat the heart burn, sore throat and productive cough. Review of a Resident #1's physician's orders dated 11/18/22 revealed: -There was an order for Azithromycin 250mg, take two tablets day one and then one tablet daily for 4 days (Azithromycin is an antibiotic used to treat infection). -There was an order for Benzoate 100mg capsules three times a day for three days (Benzoate is a medication used to treat cough). -There was an order for Mylanta	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 43 400-400-40mg/5mL, take 20 mL three times as day as needed for upset stomach (Mylanta is a medication used to treat indigestion). Interview with Resident #1 on 11/22/22 at 6:45am revealed: -She had a productive cough with green sputum starting last week. -She was coughing so badly over the weekend that she vomited on her bed sheets. -She saw her PCP last week and was ordered antibiotics and cough medication. -She had not received the medication yet. -She asked the medication aide (MA) and was told she would have to wait until the Administrator came to the facility. -She had not seen the Administrator yet to get her medication. -She felt "drained", and the coughing kept her awake over the weekend. -She coughed so much over the weekend that she vomited in her bed. Review of Resident #1's November 2022 medication administration record revealed: -There was no entry for Azithromycin 250mg, take two tablets day one and then one tablet daily for 4 days. -There was no entry for Benzoate 100mg capsules three times a day for three days. -There was no entry for Mylanta 400-400-40mg/5mL, take 20 mL three times as day as needed for upset stomach. Observation of Resident #1's medications on hand on 11/22/22 at 10:45am revealed: -There was no Azithromycin 250mg available for administration. -There was no Benzoate 100mg available for administration.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 44 -There was no Mylanta 400-400-40mg/5mL available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed: -The pharmacy received Resident #1's orders for the Zither, Benzoate and Mylanta on 11/19/22. -The Azithromycin, Benzoate and Mylanta were dispensed and delivered to the facility on 11/21/22 because delivery was set up to the facility on Mondays. Interview with Administrator on 11/22/22 at 12:19pm revealed: -Medications were delivered from the facility's contracted pharmacy to the facility at night. -The staff that was on duty at the facility received the medications and checked them. -There was only one staff member besides the Administrator and that was a medication aide (MA) who was at the facility at night and received and checked the medications. -The pharmacy recorded medications and medication changes on the resident's medication administration records (MAR). Second interview with the Administrator on 11/22/22 at 12:45pm revealed: -Resident #1's medication arrived at the facility on 11/21/22 but the MA was not aware that the medication was there for administration. -He was not aware that Resident #1 was feeling sick, or he would have gotten her medication earlier. Observation of Resident #1's medications on hand on 11/22/22 at 12:45pm revealed there was a brown paper bag that the Administrator had in his hand with Resident #1's new medication from	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 45	C 330		

the pharmacy including Azithromycin 250mg, Benzoate 100mg, and Mylanta 400-400-40mg/5mL available for administration.

Telephone interview with Resident #1's PCP on 11/22/22 at 8:35am revealed:
-She expected Resident #1 to receive her ordered medications within 1 to 2 days.
-It was important for Resident #1 to get her ordered antibiotics to treat her bronchitis.
-If Resident #1 would have received her antibiotic and cough medication as ordered it would have prevented further discomfort for the resident.

Second interview with Resident #1 on 11/22/22 at 3:45pm revealed:
-She still had not received her medications.
-She was going to ask the Administrator for her medication.

Refer to the telephone interview with the facility's contracted PCP on 11/22/22 at 8:35am.

b. Review of Resident #1 physician's orders dated 04/21/22 revealed there was an order for Ativan 1mg, take ½ tablet (0.5mg) twice a day (Ativan is a medication used to treat anxiety).

Interview with Resident #1 on 11/22/22 at 6:45am revealed:
-She was prescribed Ativan to help treat her anxiety.
-There was a time that she was not receiving the medication for about a week sometime in October.
-When she did not have her Ativan medication it made her very anxious.

Observation of Resident #1's medications on hand on 11/22/22 at 9:10am revealed there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 46 44 ½ tablets of Ativan 1mg available for administration. Telephone interview with the facility's contracted pharmacy on 11/22/22 at 12:20pm revealed: -The pharmacy dispensed 60 tablets of Ativan 1mg, ½ tablets on 11/04/22 (a 30 day supply). -The pharmacy dispensed 60 tablets of Ativan 1mg, ½ tablets on 09/06/22 (a 30 day supply). Observation of Resident #1's September 2022 medication administration record (MAR) revealed: -There was an entry for Ativan 1mg, take ½ tablet twice a day, scheduled for administration 8:00am and 8:00pm. - Ativan 1mg, take ½ tablet twice a day was documented as administered twice a day from 09/01/22 to 09/30/22. Review of Resident #1's October 2022 MAR revealed: -There was an entry for Ativan 1mg, take ½ tablet twice a day, scheduled for administration 8:00am and 8:00pm. - Ativan 1mg, take ½ tablet twice a day was documented as administered twice a day from 10/01/22 to 10/31/22. Review of Resident #1's November 2022 MAR revealed: -There was an entry for Ativan 1mg, take ½ tablet twice a day, scheduled for administration 8:00am and 8:00pm. - Ativan 1mg, take ½ tablet twice a day was documented as administered twice a day from 11/01/22 to 11/21/22. Review of Resident #1's control substance count logs for Ativan 1mg, with instructions to take ½ tablet 2 times a day revealed there was no	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 47	C 330		

documentation of administration.

Interview with the medication aide (MA) on 11/22/22 at 2:00pm revealed:
-He administered the medications in the front of the medication drawer to the resident in the morning and the back of the medication cart at night.
-He did not look at the MAR when administering medications.
-He did not sign a controlled substance count log when he administered Resident #1's Ativan.

Interview with the Administrator on 11/22/22 at 2:22pm revealed he was not aware of a time when Resident #1 was without Ativan.

Telephone interview with Resident #1's primary care provider (PCP) on 11/22/22 at 8:35am revealed:
-Resident #1 was prescribed Ativan to help control her anxiety.
-If Resident #1 went without Ativan for a prolonged period of time it could cause an increase in anxiety and potential withdraw symptoms from the medication.

Refer to the telephone interview with the facility's contracted PCP on 11/22/22 at 8:35am.

2. Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included schizophrenia, Type 2 diabetes, hypertension, and hypertriglyceridemia (elevated triglycerides in the blood).

a. Review of Resident #2's physician order sheet dated 02/23/22 revealed there was an order for Austedo 6mg twice daily with food (Austedo is used to treat tardive dyskinesia which is a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 48 movement disorder that causes a range of repetitive muscle movements in the face, neck, arms, and legs). Review of Resident's #2's physician order sheet dated 08/26/22 revealed there was an order from his mental health provider (MHP) to increase Austedo to 9mg twice a day. Review of Resident #2's September 2022 medication administration record (MAR) revealed: -There was an entry for Austedo 6mg twice daily with food scheduled for administration at 8:00am and 5:00pm. -Austedo 6mg was documented as administered at 8:00am and 5:00pm 09/01/22 to 09/30/22. Review of Resident #2's October 2022 medication administration record (MAR) revealed: -There was an entry for Austedo 6mg twice daily with food scheduled for administration at 8:00am and 5:00pm. -Austedo 6mg was documented as administered at 8:00am and 5:00pm 10/01/22 to 10/31/22. Review of Resident #2's November 2022 medication administration record (MAR) revealed: -There was an entry for Austedo 6mg twice daily with food scheduled for administration at 8:00am and 5:00pm. -Austedo 6mg was not documented as administered at 8:00am and 5:00pm 11/01/22 to 11/22/22. Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no Austedo on the medication cart for Resident #2. Intermittent observations of Resident #2 on	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 49 11/22/22 from 6:59am to 7:50am revealed no involuntary muscle movements were seen. Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day. Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed: -He had not noticed that Resident #2 was out of Austedo. -The Administrator usually reordered medication for residents when they needed it. Interview with the Administrator on 11/22/22 at 12:19pm revealed: -Resident #2's primary care providers (PCP) called any medication changes into the facility's contracted pharmacy. -It was the facility's responsibility to make sure that residents were receiving the correct dosage of medication. -The pharmacy recorded medications and medication changes on the resident's medication administration records (MAR). -He or the MA should call the pharmacy if they noticed that a medication dosage for a resident was incorrect. -Previously there was a Registered Nurse who came to the facility to audit medications and MARs but he had not had a nurse at the facility since February 2021. -He was not aware that Resident #2 continued to receive Austedo 6mg instead of the ordered 9mg. -Resident medications were received the first of every month. -Resident #2 just ran out of Austedo and he called the facility's contracted pharmacy on 11/21/22 to reorder it.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 50	C 330		

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed:
-The current order on file for Resident #2 was Austedo 6mg twice a day.
-The pharmacy had not received an order to increase Resident #2's Austedo to 9mg twice a day.
-It was the facility's responsibility to make sure the pharmacy was aware of medication changes for residents.
-Resident #2's Austedo was received from a specialty pharmacy, so he did not have dispensing records for it.

Telephone interview with a staff member at the facility's contracted specialty pharmacy on 11/22/22 at 1:25pm revealed:
-A 30-day supply of Austedo 6mg was last dispensed to Resident #2 on 08/14/22.
-Austedo 9mg had never been dispensed to Resident #2.

Telephone interview with Resident #2's MHP on 11/22/22 at 1:52pm revealed:
-She increased Resident #2's Austedo to 9mg on 08/26/22 because the resident was having increased involuntary muscle movements caused by his tardive dyskinesia.
-She was not aware that Resident #2's Austedo was never increased to 9mg as ordered.
-She was not aware that Resident #2 had not received any Austedo since sometime in September 2022.
-She called prescriptions into the pharmacy for Resident #2, but it was still the facility's responsibility to make sure that Resident #2 was receiving the correct dosage of medication and to make sure he received refills on his medication.
-She was not sure of the exact date she last saw

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 51	C 330		

Resident #2, but she saw the resident every month and at her last visit it seemed that his involuntary muscle movements had improved.

b. Review of Resident #2's physician order dated 03/14/22 revealed there was an order for glimepiride 4mg with breakfast or main meal of the day (Glimepiride is used to treat high blood sugar levels).

Review of Resident #2's laboratory sheet revealed:
-A Hemoglobin A1C was performed on Resident #2 on 08/15/22 (Hemoglobin A1C is a blood test which measures average blood sugar levels over the past 3 months).
-Resident #2's A1C was 7.5% on 08/15/22.
-The lab sheet stated, "For someone with known diabetes, a value greater than or equal to 7.0% indicates suboptimal control."

Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed:
-He had not noticed that Resident #2 was out of glimepiride.
-The Administrator usually reordered medication for residents when they needed it.

Interview with the Administrator on 11/22/22 at 12:19pm revealed:
-Resident medications were received the first of every month.
-Resident #2 just ran out of glimepiride and he called the facility's contracted pharmacy yesterday to reorder it.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed:
-A 30-day supply of glimepiride was last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 52	C 330		

dispensed for Resident #2 on 10/05/22.
-No one had reordered Resident #2's glimepiride.
-There were no refills on Resident #2's glimepiride.

Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no glimepiride on the medication cart for Resident #2.

Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day.

Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am.

c. Review of Resident #2's current FL-2 dated 02/16/22 revealed there was an order for pantoprazole 40mg daily (Pantoprazole is used to decrease stomach acid).

Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no pantoprazole on the medication cart for Resident #2.

Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day.

Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed:
-He had not noticed that Resident #2 was out of pantoprazole.
-The Administrator usually reordered medication for residents when they needed it.

Interview with the Administrator on 11/22/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 53	C 330		

12:19pm revealed:
-Resident medications were received the first of every month.
-Resident #2 just ran out of pantoprazole and he called the facility's contracted pharmacy yesterday to reorder his pantoprazole.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed:
- A 30-day supply of pantoprazole was last dispensed for Resident #2 on 10/05/22.
-No one had reordered Resident #2's pantoprazole.
-There were no refills on Resident #2's pantoprazole.

Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am.

d. Review of Resident #2's current FL-2 dated 02/16/22 revealed there was an order for Trilipix DR 135mg daily (Trilipix DR is used to treat high cholesterol).

Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no Trilipix DR on the medication cart for Resident #2.

Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day.

Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed:
-He had not noticed that Resident #2 was out of Trilipix DR.
-The Administrator usually reordered medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 54 for residents when they needed it. Interview with the Administrator on 11/22/22 at 12:19pm revealed: -Resident medications were received the first of every month. -Resident #2 just ran out of Trilipix DR and he called the facility's contracted pharmacy yesterday to reorder it. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed: -A 30-day supply of Trilipix DR was last dispensed for Resident #2 on 10/05/22. -No one had reordered Resident #2's Trilipix DR. -There were no refills on Resident #2's Trilipix DR. Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am. e. Review of Resident #2's physician order sheet dated 07/28/22 revealed there was an order for olanzapine ODT 10mg every morning (Olanzapine ODT is used to treat schizophrenia). Review of Resident #2's physician order sheet dated 08/21/22 revealed there was an order to decrease olanzapine ODT to 5mg daily. Observation of Resident #2's medication on hand on 11/22/22 at 12:23pm revealed: -There were 31 tablets of olanzapine ODT 10mg on the medication cart for Resident #2 which were dispensed on 08/13/22. -There were 30 tablets of olanzapine ODT 10mg on the medication cart for Resident #2 which were dispensed on 09/13/22.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 55 -There was no olanzapine 5mg on the cart for Resident #2. Review of Resident #2's September 2022 medication administration record (MAR) revealed: -There was an entry for olanzapine ODT 10mg dissolve 1 tablet by mouth every morning for mood. -Olanzapine ODT 10mg was documented as administered 09/01/22 to 09/30/22. Review of Resident #2's October 2022 MAR revealed: -There was an entry for olanzapine ODT 10mg dissolve 1 tablet by mouth every morning for mood. -Olanzapine ODT 10mg was documented as administered 10/01/22 to 10/31/22. Review of Resident #2's November 2022 MAR revealed: -There was an entry for olanzapine ODT 10mg dissolve 1 tablet by mouth every morning for mood. -Olanzapine ODT 10mg was documented as administered 11/01/22 to 11/21/22. Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day. Interview with the Administrator on 11/22/22 at 12:25pm revealed: -The primary care provider (PCP) called medication changes into the facility's contracted pharmacy. -It was the facility's responsibility to make sure residents were receiving the correct dosage of medication. -He or the medication aide (MA) should call the	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

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ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 56	C 330		

pharmacy if they noticed that a medication dosage for a resident was incorrect.
-He did not know why Resident #2 had olanzapine ODT 10mg on the medication cart instead of olanzapine ODT 5mg as ordered.
-He did not know why Resident #2 had so many tablets of olanzapine ODT on the medication cart that were dispensed August 2022 and September 2022.

Refer to telephone interview with Resident #2's PCP on 11/22/22 at 8:35am.

f. Review of a physician order sheet for Resident #2 dated 02/23/22 revealed there was an order for trazodone 150mg every night (Trazodone is used to treat depression and anxiety).

Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no trazodone on the medication cart for Resident #2.

Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day.

Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed:
-He had not noticed that Resident #2 was out of trazodone.
-The Administrator usually reordered medication for residents when they needed it.

Interview with the Administrator on 11/22/22 at 12:19pm revealed:
-Resident medications were received the first of every month.
-Resident #2 just ran out of trazodone and he called the facility's contracted pharmacy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 57 yesterday to reorder it. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed: -A 30-day supply of trazodone was last dispensed for Resident #2 on 10/05/22. -No one had reordered Resident #2's trazadone. Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am. g. Review of Resident #2's current FL-2 dated 02/16/22 revealed there was an order for Lipitor 40mg daily (Lipitor is used to treat elevated cholesterol). Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no Lipitor on the medication cart for Resident #2. Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day. Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed: -He had not noticed that Resident #2 was out of Lipitor. -The Administrator usually reordered medication for residents when they needed it. Interview with the Administrator on 11/22/22 at 12:19pm revealed: -Resident medications were received the first of every month. -Resident #2 just ran out of Lipitor and he called the facility's contracted pharmacy yesterday to reorder it.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 58 Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed: -A 30-day supply of Lipitor was last dispensed for Resident #2 on 10/05/22. -No one had reordered Resident #2's Lipitor. -There were no refills on Resident #2's Lipitor. Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am. h. Review of Resident #2's current FL-2 dated 02/16/22 revealed there was an order for Miralax 17gm as directed daily (Miralax is used to treat constipation). Review of Resident #2's physician order sheet dated 07/08/22 revealed there was an order to stop Miralax daily and start Miralax 17gm as needed, hold for loose stools. Review of Resident #2's September 2022 medication administration record (MAR) revealed: -There was an entry for Miralax mix 17gm in 8 ounces of water or juice and drink daily scheduled for administration at 8:00am. -Miralax 17g was documented as administered at 8:00am 09/01/22 to 09/30/22. Review of Resident #2's October 2022 medication administration record (MAR) revealed: -There was an entry for Miralax mix 17gm in 8 ounces of water or juice and drink daily scheduled for administration at 8:00am. -Miralax 17g was documented as administered at 8:00am 10/01/22 to 10/31/22. Review of Resident #2's November 2022	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 59	C 330		

medication administration record (MAR) revealed:
-There was an entry for Miralax mix 17gm in 8 ounces of water or juice and drink daily scheduled for administration at 8:00am.
-Miralax 17g was documented as administered at 8:00am 11/01/22 to 11/21/22.

Interview with Resident #2 on 11/22/22 at 6:59am revealed as far as he knew he received all his medications every day.

Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed:
-He was not aware that Resident #2 should not be getting Miralax daily.
-He was administering Miralax to Resident #2 every day because that was the order on the MAR.
-He was not aware of Resident #2 having any loose stools.

Interview with the Administrator on 11/22/22 at 12:25pm revealed:
-The primary care provider (PCP) called medication changes into the facility's contracted pharmacy.
-It was the facility's responsibility to make sure residents were receiving the correct medication at the correct time.

Refer to telephone interview with Resident #2's PCP on 11/22/22 at 8:35am.

3. Review of Resident #3's FL-2 dated 10/26/22 revealed:
-Diagnoses included hypertension, history of a stroke, atrial fibrillation, and memory loss.
-There was an order for Norvasc 10mg daily (Norvasc is a medication used to treat hypertension).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 60 -There was an order for Aspirin 81mg daily (Aspirin anti-inflammatory medications used as a preventative for heart health). -There was an order for Vitamin D3 2,000 units daily (Vitamin D3 is a vitamin supplement used to treat Vitamin D3 deficiency). -There was an order for Lisinopril 10mg daily (Lisinopril is a medication used to treat hypertension. -There was an order for Multivitamin 1 tablet to be administered with supper (Multivitamin is a vitamin supplement). -There was an order for Eliquis 5mg daily (Eliquis is a medication used to thin blood cells to prevent clots). Review of the Resident #3's Resident Register revealed he was admitted to the facility from a local hospital on 10/27/22. Review of Resident #3's facility record revealed there was no October 2022 medication administration record (MAR) available for review. Review of Resident #3's facility record revealed there was no November 2022 MAR available for review. Observation of Resident #3 on 11/22/22 at 8:15am revealed the medication aide (MA) administered him medication. Observation of Resident #3's medications on hand revealed: -There was Norvasc 10mg, with instructions to be administered once daily, in a prescription bottle. -There was Aspirin 81mg, with instructions to be administered once daily, in a prescription bottle. -There was Vitamin D3 2,000 units, in an over the counter medication bottle.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 61 -There was Lisinopril 10mg, with instructions to be administered once daily, in a prescription bottle. -There was Multivitamin tablets, in an over the counter medication bottle. -There was Eliquis 5mg, with instructions to be administered once daily. Interview with the MA that administered Resident #3's medications on 11/22/22 at 8:15am revealed: -They were waiting on the insurance company to approve Resident #3's medication so he did not have a MAR for him to document on. -He administered daily medications to Resident #3 based on what the prescription bottle said on the label. -The resident came to the facility with medications for administration. Refer to telephone interview with Resident #2's PCP on 11/22/22 at 8:35am. _____ Telephone interview with the facility's primary care provider (PCP) on 11/22/22 at 8:35am revealed: -She expected the residents to receive their medications as ordered. -She expected medications to be available for administration to the residents as ordered. -It was important for the residents to receive their medications as ordered in order to meet their medical needs. _____ The facility failed to ensure medications were administered as ordered for medications including an antibiotic and cough suppression prescribed for bronchitis that delayed treatment of a respiratory infection in a resident who was coughing so badly over the weekend that she vomited on her bed sheets (#1). The facility ran out of a medication used to treat anxiety for	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 330	Continued From page 62 Resident #1 which caused the resident to have increased anxiety and placed the resident at potential risk of medication withdrawal. The facility did not have 8 medications on hand to administer for Resident #2 including a medication to treat diabetes in a resident who had an elevated hemoglobin A1C of 7.5, as well as medications used to treat diagnoses including tardive dyskinesia, acid reflux, high cholesterol, schizophrenia, anxiety, and constipation. This failure resulted in substantial risk for serious physical harm and constitutes a Type A2 violation. The facility did not provide an acceptable plan of protection in accordance with G.S. 131D-34 on 11/22/22 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 22, 2022.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by:	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 341	Continued From page 63 Based on observations, interviews, and record reviews, the facility failed to ensure medications administered were documented upon administration for 3 of 3 residents sampled (#1, #2, and #3). The findings are: 1. Review of Resident #1's most recent FL-2 dated 03/31/21 revealed diagnoses included schizoaffective disorder, bipolar disorder and hyperlipidemia. Observation of Resident #1 on 11/22/22 revealed that she received medications from the medication aide (MA) at 7:06am. Review of Resident #1's November 2022 medication administration record (MAR) revealed: -There was an entry for Lexapro 40mg daily scheduled for administration at 8:00am (Lexapro is a medication used to treat depression). -Lexapro 40mg was not documented as administered at 8:00am on 11/22/22. -There was an entry for Crestor 10mg daily scheduled for administration at 8:00am (Crestor is a medication used to treat high cholesterol). -Crestor 10mg was not documented as administered at 8:00am on 11/22/22. -There was an entry for Atenolol 25mg, 1/2 tablet twice a day scheduled for administration at 8:00am and 8:00pm (Atenolol is a medication used to treat high blood pressure). -Atenolol 25mg, 1/2 tablet was not documented as administered at 8:00am on 11/22/22. -There was an entry for Ativan 1mg, take 1/2 tablet twice a day scheduled for administration at 8:00am and 8:00pm (Ativan is a medication used to treat anxiety). -Ativan 1mg, take 1/2 tablet was not documented	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 341	Continued From page 64	C 341		

as administered at 8:00am on 11/22/22.
-There was an entry for Propanolol 20mg take twice a day scheduled for administration at 8:00am and 8:00pm (Propanolol is a medication used to treat high blood pressure).
-Propanolol 20mg was not documented as administered at 8:00am on 11/22/22.
-There was an entry for Vimpat 50mg twice a day, scheduled for administration at 8:00am and 8:00pm (Vimpat is a medication used to treat seizure disorder).
-Vimpat was not documented as administered at 8:00am on 11/22/22.

Refer to interview with the MA on 11/22/22 at 9:05am.

Refer to second interview with the MA on 11/22/22 at 2:00pm.

Refer to interview with the Administrator on 11/22/22 at 2:17pm.

2. Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included schizophrenia, Type 2 diabetes, hypertension, and chronic obstructive pulmonary disease (COPD) (a lung disease that blocks airflow and makes it difficult to breathe).

Observation of Resident #2 on 11/22/22 revealed he received medications from the medication aide (MA) at 7:15am.

Review of Resident #2's November 2022 medication administration record (MAR) revealed:
-There was an entry for aspirin 81mg every day for heart health scheduled for administration at 8:00am.
-Aspirin 81mg was not documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 341	Continued From page 65	C 341		

administered at 8:00am on 11/22/22.
-There was an entry for Januvia 100mg daily for diabetes scheduled for administration at 8:00am.
-Januvia 100mg was not documented as administered at 8:00am on 11/22/22.
-There was an entry for magnesium oxide 400mg daily for supplement scheduled for administration at 8:00am.
-Magnesium oxide 400mg was not documented as administered at 8:00am on 11/22/22.
-There was an entry for Miralax 17gm in 8 ounces of water or juice daily for constipation scheduled for administration at 8:00am.
-Miralax 17gm was not documented as administered at 8:00am on 11/22/22.
-There was an entry for amlodipine besylate 5mg every morning for hypertension scheduled for administration at 8:00am.
-Amlodipine besylate 5mg was not documented as administered at 8:00am on 11/22/22.
-There was an entry for lisinopril 10mg every day for blood pressure scheduled for administration at 8:00am.
-Lisinopril 10mg was not documented as administered at 8:00am on 11/22/22.
-There was an entry for olanzapine ODT 10mg every morning for mood scheduled for administration at 8:00am.
-Olanzapine ODT 10mg was not documented as administered at 8:00am on 11/22/22.
-There was an entry for metformin HCL 1000mg twice a day with meals for diabetes scheduled for administration at 8:00am and 5:00pm.
-Metformin HCL 1000mg was not documented as administered at 8:00am on 11/22/22.
-There was an entry for serevent diskus 50mcg inhale 1 puff twice a day for COPD scheduled for administration at 8:00 am and 8:00pm.
-Serevent diskus 50mcg was not documented as administered at 8:00am on 11/22/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 341	Continued From page 66 -There was an entry for quetiapine fumarate 25mg twice daily for mood scheduled for administration at 8:00am and 8:00pm. -Quetiapine fumarate 25mg was not documented as administered at 8:00am on 11/22/22. Refer to interview with the MA on 11/22/22 at 9:05am. Refer to second interview with the MA on 11/22/22 at 2:00pm. Refer to interview with the Administrator on 11/22/22 at 2:17pm. 3. Review of Resident #3's FL-2 dated 10/26/22 revealed: -Diagnoses included hypertension, history of a stroke, atrial fibrillation, and memory loss. -There was an order for Norvasc 10mg daily (Norvasc is a medication used to treat hypertension). -There was an order for Aspirin 81mg daily (Aspirin anti-inflammatory medications used as a preventative for heart health). -There was an order for Vitamin D3 2,000 units daily (Vitamin D3 is a vitamin supplement used to treat Vitamin D3 deficiency). -There was an order for Lisinopril 10mg daily (Lisinopril is a medication used to treat hypertension. -There was an order for Multivitamin 1 tablet to be administered with supper (Multivitamin is a vitamin supplement). -There was an order for Eliquis 5mg daily (Eliquis is a medication used to thin blood cells to prevent clots). Review of Resident #3's facility record revealed there was no November 2022 medication	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 341	Continued From page 67 administration record (MAR) available for review. Observation of Resident #3 on 11/22/22 at 8:15am revealed the medication aide (MA) administered him medication. Interview with the MA that administered Resident #3's medications on 11/22/22 at 8:15am revealed they were waiting on the insurance company to approve Resident #3's medication so he did not have a MAR for him to document on. Refer to interview with the MA on 11/22/22 at 9:05am. Refer to second interview with the MA on 11/22/22 at 2:00pm. Refer to interview with the Administrator on 11/22/22 at 2:17pm. _____ Interview with the medication aide (MA) on 11/22/22 at 9:05am revealed he administered Resident #1's and Resident #2's morning medications before the residents went to a day program. Second interview with the medication aide (MA) at 2:00pm revealed he waited until the end of the day to document the medications he administered throughout the day. Interview with the Administrator on 11/22/22 at 2:17pm revealed: -He expected the MA to document medications as soon as they were administered. -The MA should not document administration of resident medications at the end of the day.	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 68	C 342		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were complete and accurate for 2 of 2 residents sampled (#1 and #2). The findings are: 1. Review of Resident #1's most recent FL-2 dated 03/31/21 revealed diagnoses included schizoaffective disorder, bipolar disorder and hyperlipidemia.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

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ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 69 Review of Resident #1's physician order dated 05/18/22 revealed there was an order to start Nicotine gum 4mg, with instructions to chew 1 piece of gum by mouth for 30 minutes up to 24 times a day (Nicotine gum is used for smoking cessation). Review of Resident #1's physician order dated 06/19/22 revealed there was an order to discontinue the Nicotine gum. Review of Resident #1's September 2022 medication administration record (MAR) revealed: -There was an entry for Nicotine 4mg, with instructions to chew 1 piece of gum by mouth for 30 minutes up to 24 times a day as needed. -Nicotine 4mg was documented as administered once daily, with no time documented from 09/01/22 to 09/30/22. Review of Resident #1's October 2022 MAR revealed: -There was an entry for Nicotine 4mg, with instructions to chew 1 piece of gum by mouth for 30 minutes up to 24 times a day as needed. -Nicotine 4mg was documented as administered once daily, with no time documented from 10/01/22 to 10/31/22. Review of Resident #1's November 2022 MAR revealed: -There was an entry for Nicotine 4mg, with instructions to chew 1 piece of gum by mouth for 30 minutes up to 24 times a day as needed. -Nicotine 4mg was documented as administered once daily, with no time documented from 11/01/22 to 11/21/22. Observation of Resident #1's medications on hand on 11/22/22 revealed there was no Nicotine	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

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ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 70 gum available for administration. Telephone interview with the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed they had no record of dispensing nicotine gum for Resident #1. Interview with Resident #1 on 11/22/22 at 3:30pm revealed she did not chew Nicotine gum and has not in over a year. Interview with the medication aide (MA) on 11/22/22 at 2:00pm revealed he was not sure why he signed off the Nicotine gum even though it was not administered. Interview with the Administrator on 11/22/22 at 1:45pm revealed: -Resident #1 must have just run out Nicotine gum yesterday. -The MA should not be documenting administering Nicotine gum if Resident #1 did not receive the medication. Refer to telephone interview with the facility's primary care provider (PCP) on 11/22/22 at 8:35pm. 2. Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included schizophrenia, Type 2 diabetes, hypertension, and hypertriglyceridemia (elevated triglycerides in the blood). a. Review of Resident #2's physician order dated 03/14/22 revealed there was an order for glimepiride 4mg (used to treat high blood sugar) with breakfast or main meal of the day. Observation of Resident #2's medications on	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 71	C 342		

hand on 11/22/22 at 12:23pm revealed there was no glimepiride on the medication cart for Resident #2.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed a 30-day supply of glimepiride was last dispensed for Resident #2 on 10/05/22.

Review of Resident #2's November 2022 medication administration record (MAR) revealed:
-There was an entry for glimepiride 4mg with breakfast or main meal of the day scheduled at 8:00am.
-Glimepiride 4mg was documented as administered at 8:00am 11/01/22 to 11/21/22.

Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed:
-He did not know that Resident #2 was out of glimepiride.
-He should not have documented on the MAR that he gave medications that were not in the facility.
-He gave Resident #2 the medications he had at the time and must have initialed that he gave the glimepiride in error.

Interview with the Administrator on 11/22/22 at 12:19pm revealed the MA should not be documenting medications that he was not administering.

Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am.

b. Review of Resident #2's current FL-2 dated 02/16/22 revealed there was an order for atorvastatin 40mg (used to treat high cholesterol)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 72	C 342		

daily.

Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no atorvastatin on the medication cart for Resident #2.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed a 30-day supply of atorvastatin was last dispensed for Resident #2 on 10/05/22.

Review of Resident #2's November 2022 medication administration record (MAR) revealed:
-There was an entry for atorvastatin 40mg at bedtime scheduled for 8:00pm.
-Atorvastatin 40mg was documented as administered at 8:00pm 11/01/22 to 11/21/22.

Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed:
-He did not know that Resident #2 was out of atorvastatin.
-He should not have documented on the MAR that he gave medications that were not in the facility.
-He gave Resident #2 the medications he had at the time and must have initialed that he gave the atorvastatin in error.

Interview with the Administrator on 11/22/22 at 12:19pm revealed the MA should not be documenting medications that he was not administering.
Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am.

c. Review of Resident #2's current FL-2 dated 02/16/22 revealed there was an order for Trilipix

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 73 DR 135mg (used to treat high cholesterol) daily. Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no Trilipix DR on the medication cart for Resident #2. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed a 30-day supply of Trilipix DR was last dispensed for Resident #2 on 10/05/22. Review of Resident #2's November 2022 medication administration record (MAR) revealed: -There was an entry for Trilipix DR 135mg daily scheduled for administration at 8:00am. -Trilipix DR 135mg was documented as administered at 8:00am on 11/01/22 to 11/21/22. Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed: -He did not know that Resident #2 was out of Trilipix DR. -He should not have documented on the MAR that he gave medications that were not in the facility. -He gave Resident #2 the medications he had at the time and must have initialed that he gave the Trilipix DR in error. Interview with the Administrator on 11/22/22 at 12:19pm revealed the MA should not be documenting medications that he was not administering. Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am. d. Review of Resident #2's current FL-2 dated	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 342	Continued From page 74 02/16/22 revealed there was an order for pantoprazole 40mg (used to decrease stomach acid) daily. Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no pantoprazole on the medication cart for Resident #2. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed a 30-day supply of pantoprazole was last dispensed for Resident #2 on 10/05/22. Review of Resident #2's November 2022 medication administration record (MAR) revealed: -There was an entry for pantoprazole 40mg daily scheduled for administration at 8:00am. -Pantoprazole 40mg was documented as administered at 8:00am on 11/01/22 to 11/21/22. Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed: -He did not know that Resident #2 was out of pantoprazole. -He should not have documented on the MAR that he gave medications that were not in the facility. -He gave Resident #2 the medications he had at the time and must have initialed that he gave the pantoprazole in error. Interview with the Administrator on 11/22/22 at 12:19pm revealed the MA should not be documenting medications that he was not administering. Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 75 8:35am. e. Review of a physician order sheet for Resident #2 dated 02/23/22 revealed there was an order for trazodone 150mg (used to treat depression and anxiety) every night. Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no trazodone on the medication cart for Resident #2. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed a 30-day supply of trazodone was last dispensed for Resident #2 on 10/05/22. Review of Resident #2's November 2022 medication administration record (MAR) revealed: -There was an entry for trazodone 150mg nightly scheduled for administration at 8:00pm. -Trazodone 150mg was documented as administered at 8:00pm on 11/01/22 to 11/21/22. Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed: -He did not know that Resident #2 was out of trazodone. -He should not have documented on the MAR that he gave medications that were not in the facility. -He gave Resident #2 the medications he had at the time and must have initialed that he gave the trazodone in error. Interview with the Administrator on 11/22/22 at 12:19pm revealed the MA should not be documenting medications that he was not administering.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 342	Continued From page 76 Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am. f. Review of Resident #2's physician order sheet dated 02/23/22 revealed there was an order for Austedo 6mg twice daily with food (Austedo is used to treat tardive dyskinesia which is a movement disorder that causes a range of repetitive muscle movements in the face, neck, arms, and legs). Review of Resident's #2's physician order sheet dated 08/26/22 revealed there was an order from his mental health provider (MHP) to increase Austedo to 9mg twice a day. Observation of Resident #2's medications on hand on 11/22/22 at 12:23pm revealed there was no Austedo on the medication cart for Resident #2. Telephone interview with a staff member at the facility's contracted specialty pharmacy on 11/22/22 at 1:25pm revealed a 30-day supply of Austedo 6mg was last dispensed to Resident #2 on 08/14/22. Review of Resident #2's September 2022 medication administration record (MAR) revealed: -There was an entry for Austedo 6mg twice daily with food scheduled for administration at 8:00am and 5:00pm. -Austedo 6mg was documented as administered at 8:00am and 5:00pm 09/01/22 to 09/30/22. Review of Resident #2's October 2022 medication administration record (MAR) revealed: -There was an entry for Austedo 6mg twice daily with food scheduled for administration at 8:00am	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 342	Continued From page 77 and 5:00pm. -Austedo 6mg was documented as administered at 8:00am and 5:00pm 10/01/22 to 10/31/22. Interview with the medication aide (MA) on 11/22/22 at 2:42pm revealed: -He did not know that Resident #2 was out of Austedo. -He should not have documented on the MAR that he gave medications that were not in the facility. -He gave Resident #2 the medications he had at the time and must have initialed that he gave the Austedo in error. Interview with the Administrator on 11/22/22 at 12:19pm revealed the MA should not be documenting medications that he was not administering. Refer to telephone interview with Resident #2's primary care provider (PCP) on 11/22/22 at 8:35am. _____ Telephone interview with the facility's primary care provider (PCP) on 11/22/22 at 8:35am revealed: -She expected the resident's medication administration record to accurately reflect the medications being administered. -She expected the resident's medication administration records (MAR) to match what medications were ordered for the residents.	C 342		
C 346	10A NCAC 13G .1004(n) Medication Administration 10A NCAC 13G .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control	C 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 346	Continued From page 78	C 346		

measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered in accordance with infection control measures to prevent the development and transmission of disease or infection, prevent cross-contamination, and provide a safe and sanitary environment for staff and residents when administering 1 of 1 resident's morning medication (Resident #3).

The findings are:

Review of Resident #3's FL-2 dated 10/26/22 revealed:
-Diagnoses included hypertension, history of a stroke, atrial fibrillation, and memory loss.
-There was an order for Norvasc 10mg daily (Norvasc is a medication used to treat hypertension).
-There was an order for Aspirin 81mg daily (Aspirin anti-inflammatory medications used as a preventative for heart health).
-There was an order for Vitamin D3 2,000 units daily (Vitamin D3 is a vitamin supplement used to treat Vitamin D3 deficiency).
-There was an order for Lisinopril 10mg daily (Lisinopril is a medication used to treat hypertension.
-There was an order for Multivitamin 1 tablet to be administered with supper (Multivitamin is a vitamin supplement).
-There was an order for Eliquis 5mg daily (Eliquis is a medication used to thin blood cells to prevent clots).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 346	Continued From page 79 Observation of the medication aide (MA) on 11/22/22 at 8:15am revealed: -The MA did not use the hand sanitizer that was on the medication cart. -The MA pulled out a plastic bag of pill bottles from the medication cart. -The MA proceeded to pour the medications out of the bottles into his hand and then place in a plastic cup. -The MA administered the medications in the cup to Resident #3. Review of the Resident #3's Resident Register revealed he was admitted to the facility from a local hospital on 10/27/22. Review of Resident #3's facility record revealed there was no November 2022 medication administration record (MAR) available for review. Interview with the MA on 11/22/22 at 12:26pm revealed: -He should have placed the medications from the pill bottles directly into the medication cup and not touched the medications when administering Resident #3's morning medications. -He completed the infection control class in August of 2022. Interview with the Administrator on 11/22/22 at 2:22pm revealed: -The MA should have placed the medications directly from the bottle into the plastic cups for administration. -Medications should not be handled with bare hands in order to prevent the spread of infection. -The MA should have washed his hands prior to administering medications to the resident.	C 346		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

(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 346	Continued From page 80 Telephone interview with Resident #3's primary care provider (PCP) on 11/22/22 at 8:35am revealed: -She expected staff to administer medications in accordance with infection control principles including not handling medications without gloves. -She expected staff to wash their hands before and after medication administration to eliminate cross contamination and risk for spread of disease.	C 346		
C 350	10A NCAC 13G .1005 (a and b) Self-Administration Of Medications 10A NCAC 13G .1005 Self-Administration Of Medications (a) The facility shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. (b) The facility shall notify the physician when: (1) there is a change in the resident's mental or physical ability to self-administer; (2) the resident is non-compliant with the physician's orders; or (3) the resident is non-compliant with the facility's medication policies and procedures. A resident's right to refuse medications does not imply the inability of the resident to self-administer medications.	C 350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033018	A. BUILDING: _____ B. WING _____	R 11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALMARCH FAMILY CARE	1924 BEVERLY ROAD ROCKY MOUNT, NC 27801

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C 350	Continued From page 81 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that 1 of 1 residents sampled (#5) that was self-administering their own insulin injections had an order to self administer from a prescribing practioner. The findings are: Review of Resident #5's current FL-2 dated 10/25/22 revealed: -Diagnosis included schizophrenia. -There was an order for Insulin determir, 15 units to be administered at bedtime (Insulin determir is a long-acting insulin used to manage symptoms of diabetes. Review of the Resident #5's Resident Register revealed he was admitted to the facility on 11/15/22. Review of Resident #5's facility file revealed: -There was no order for self administration of Insulin determir. -There was no order for fingerstick blood sugars. Observation of Resident #5's medications on hand on 11/22/22 revealed he had Insulin determir available for administration. Interview with Resident #5 on 11/22/22 at 12:10pm revealed: -He administered his own insulin. -He administered 15 units of insulin before going to bed. -No one had been checking his blood sugars.	C 350		

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C 350	Continued From page 82 -He was last seen by his primary care provider (PCP) on 11/18/22. -His PCP informed the resident she wanted his blood sugars checked twice daily. -The PCP informed the resident she would order supplies for his blood sugars to be checked. Interview with the Administrator on 11/22/22 at 2:20pm revealed: -He administered Resident #5's insulin when he was working at the facility. -When he was not there, Resident #5 administered his own insulin. -He was not aware that Resident #5 needed a self-administration order to self-administer his medication.	C 350		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration including controlled substances for 1 of 1 medication carts. The findings are: Observation of the facility's medication cart on 11/22/22 at 7:20am revealed:	C 353		

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C 353	Continued From page 83 -The medication cart drawers were closed but the cart was unlocked. -There were two residents seated at the kitchen table near the medication cart. -Ativan was in the main compartment of the medication cart and not in the locked controlled substance drawer (Ativan is a medication used to treat anxiety). -The medication aide (MA) was down the hallway in a resident's room. Interview with the medication aide (MA) on 11/22/22 at 8:15am revealed: -He did not lock the medication cart when he was in the area or when he was coming right back to the medication cart. -He was not aware of any residents going into the medication cart on their own without him. A second observation of the medication cart on 11/22/22 at 12:12pm revealed: -The medication cart was unlocked. -There were 5 medication cards containing resident medications on top of the medication cart. -There were 3 bottles of liquid medications on top of the medication cart. -There were no staff members in the room with the unlocked medication cart. -There was an unsupervised resident sitting in the room with the unlocked medication cart. A third observation of the facility's medication cart on 11/22/22 at 1:45pm revealed: -The medication cart was unlocked. -There were two residents sitting in the living room and the MA was in his bedroom. -The Administrator was out of the facility. Interview with the Administrator on 11/22/22 at	C 353		

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C 353	Continued From page 84 2:22pm revealed: -The medication cart should be locked when the MA was not using it. -Ativan and other controlled substances should be kept in the double locked controlled box. -It was important for the medication cart to be locked so that residents stayed safe. Telephone interview with the facility's contracted primary care provider (PCP) on 11/22/22 at 8:35am revealed she expected medication storage to remain locked when not under direct supervision for resident's safety.	C 353		
C 361	10A NCAC 13G .1007 (a) Medication Disposition 10A NCAC 13G .1007 Medication Disposition (a) Medications shall be released to or with a resident upon discharge if the resident has a physician's order to continue the medication. Prescribed medications are the property of the resident and shall not be given to, or taken by, other staff or residents according to Rule .1004(o) of this Subchapter. This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure that physician-prescribed medications were released with the resident upon discharge for 1 of 1 sampled resident (#6). The findings are: Review of Resident #6's facility file revealed there was no FL-2 on admission to the facility.	C 361		

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C 361	Continued From page 85 Review of Resident #6's facility file revealed there was no medication list or physician orders for the resident. Telephone interview with Resident #6's Care Coordinator on 11/10/22 at 11:00am revealed: -Resident #6 left the facility on 11/04/22. -The resident returned to the facility on 11/09/22 to pick up medications. -The resident was given a couple of days supply of medications. -The resident's medications were all mixed together in a container. -Some of the resident's medications were loose in the container, out of their bubble packs and some bubble packs were empty. Telephone interview with Resident #6 on 12/05/22 at 2:52 pm revealed: -She was taking the following medications: Risperdal, Flonase, Maalox, Dulcolax and Vitamin B12. -She was out of Risperdal when she went back to get her medications on 11/09/22. Interview with the Administrator on 11/22/22 at 2:22pm revealed: -Resident #6 came to the facility with medications on admission. -Resident #6 was at the facility for two days and then went on a visit with a family member. -Medication was given to Resident #6's family member for four days. -Resident #6's family member returned to the facility after the four days to get more medicine for the resident. -He was not aware that Resident #6 was being discharged until he received a call later that day from Resident #6's Care Coordinator. -He was not available when the family member	C 361		

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C 361	Continued From page 86 returned to the facility to collect the rest of the medication but he was sure that it was sent with the family member when requested by staff at the facility. -He was not aware that he needed to have a record of what medications were sent with residents at discharge.	C 361		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure controlled substance records for 1 of 1 sampled resident (#1) were accurately reconciled with the administration of a controlled substance used for anxiety. The findings are: Review of Resident #1's most recent FL-2 dated 03/31/21 revealed diagnoses included schizoaffective disorder and bipolar. Review of Resident #1's primary care provider (PCP) orders dated 10/21/22 revealed there was an order for Ativan 1mg, take ½ tablet 2 times a day (Ativan is a medication used to treat anxiety). Review of Resident #1's November 2022	C 367		

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C 367	Continued From page 87	C 367		

medication administration record (MAR) from 11/01/22 to 11/22/22 revealed:
-There was an entry for Ativan 1mg, take ½ tablet 2 times a day scheduled for administration at 8:00am to 8:00pm.
-Ativan was documented as administered twice a day from 11/01/22 to 11/21/22.

Review of Resident #1's control substance count log for Ativan 1mg, with instructions to take ½ tablet 2 times a day revealed there was no documentation of administration.

Interview with Resident #1 on 11/22/22 at 6:45am revealed she took Ativan two times a day to help with anxiety.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/22/22 at 12:10pm revealed the pharmacy sent a control substance count log monthly with the controlled substances to be completed by staff for Ativan.

Interview with the medication aide (MA) on 11/22/22 at 2:00pm revealed:
-He was not aware that he needed to document on the controlled substance count log when administering Ativan to Resident #6.
-He documented on the MAR that he administered the Ativan.

Interview with the Administrator on 11/22/22 at 2:22pm revealed:
-He expected the MA to document on the controlled substance count log when administering Ativan to Resident #6.
-The MA was trained upon hire to document on the controlled substance count log but he did not audit the logs to ensure it was being done.

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C 375	Continued From page 88	C 375		
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; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain the services of a licensed	C 375		

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C 375	Continued From page 89	C 375		

pharmacist, prescribing practitioner, or registered nurse for the provision of pharmaceutical care at least quarterly for 2 of 3 residents (#1, #2) residing in the facility.

The findings are:

1. Review of Resident #2's current FL-2 dated 02/16/22 revealed diagnoses included schizophrenia, type 2 diabetes, and hypertension.

Review of Resident #2's Resident Register revealed he was admitted to the facility 02/16/21.

Review of Resident #2's record on 11/22/22 revealed there were no medication reviews in the resident's record to identify and resolve medication related problems since his admission on 02/16/21.

Review of Resident #2's medication orders, medication administration records (MAR), and medications on hand revealed medication related problems were identified during the survey that could have been identified during a medication review.

Refer to interview with the Administrator on 11/22/22 at 2:28pm.

2. Review of Resident #1's most recent FL-2 dated 03/31/21 revealed:
-Diagnoses included hyperlipidemia, epilepsy, and schizoaffective disorder.
-Resident #1 was admitted to the facility on 12/08/20.

Review of Resident #1's facility record revealed there was no Resident Register.

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C 375	Continued From page 90 Review of Resident #1's record on 11/22/22 revealed there were no medication reviews in the resident's record to identify and resolve medication related problems since 02/24/21. Review of Resident #1's medication orders, medication administration records (MAR), and medications on hand revealed medication related problems were identified during the survey that could have been identified during a medication review. Refer to interview with the Administrator on 11/22/22 at 2:28pm. _____ Interview with the Administrator on 11/22/22 at 2:28pm revealed: -Previously there was a Registered Nurse (RN) at the facility who completed medication reviews for residents. -There had not been a RN at the facility since February 2021 and that was why medication reviews had not been completed for residents. -He was working on finding a RN to complete medication reviews.	C 375		