| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| JONES FAMILY HOME #1 | 2437 EPHESUS CHURCH ROAD SEMORA, NC 27343 |

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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow-up survey from 03/20/23 to 03/21/23. | C 000 | | |
| C 145 | 10A NCAC 13G .0406(a)(5) Other Staff Qualifications<br><br>10A NCAC 13G .0406 Other Staff Qualifications<br>(a) Each staff person of a family care home shall:<br>(5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire.<br><br>The findings are:<br><br>Review of Staff A's, Supervisor-in-Charge/medication aide (SIC/MA) personnel record revealed:<br>-There was no documented date of hire.<br>-There was no documentation a HCPR check was completed prior to hire.<br><br>Interview with Staff A on 03/20/21 at 3:15pm revealed:<br>-He thought a HCPR check had been completed on him by the Director/Owner.<br>-He did not know why the HCPR results were not in his employ file.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed: | C 145 | | |

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| C 145 | Continued From page 1<br>-He had completed a HCPR on Staff A.<br>-He did not know why the HCPR results were not in Staff A's employee record, but he would look to see if it had been misplaced.<br><br>Review of Staff C's HCPR check on 03/20/23 at 3:19pm revealed Staff C had no substantiated findings.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful. | C 145 | | |
| C 236 | 10A NCAC 13G .0802 (a) Resident Care Plan<br><br>10A NCAC 13G .0802 Resident Care Plans<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record review, and interviews the facility failed to develop a care plan for 3 of 3 sampled residents (Residents #1, #2, and #3).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL2 dated 05/04/22 revealed:<br>-Diagnoses included paranoid schizoaffective disorder, bipolar type.<br>-Resident #1 had a history of wandering.<br><br>Review of Resident #1's resident register | C 236 | | |

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| C 236 | Continued From page 2<br>revealed an admission date of 10/11/22.<br><br>Review of Resident #1's record revealed:<br>-There was a blank care plan in the record.<br>-The care plan had not been completed.<br><br>Interview with Resident #1 on 03/21/23 at 9:55am revealed:<br>-He was independent with his care.<br>-The only thing staff did for him was cooked and gave him his medications.<br><br>Telephone interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He was responsible for completing care plans.<br>-Resident #1's care plan not being completed was an oversite.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br><br>Refer to the interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/21/23 at 10:55am.<br><br>2. Review of Resident #2's current FL2 dated 08/25/22 revealed:<br>-Diagnoses included schizophrenia and congestive heart failure (CHF).<br>-Resident #2 was independent with bathing, feeding, and dressing.<br><br>Review of Resident #2's resident register revealed an admission date of 10/11/22.<br><br>Review of Resident #2's record revealed:<br>-There was a blank care plan in the record.<br>-The care plan had not been completed. | C 236 | | |

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| C 236 | Continued From page 3<br><br>Telephone interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He was responsible for completing care plans.<br>-Resident #2's care plan not being completed was an oversite.<br><br>Interview with Resident #2 on 03/21/23 at 10:24am revealed:<br>-He was independent with his care.<br>-The only thing staff did for him was cooked and gave him his medications.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br><br>3. Review of Resident #3's current FL2 dated 10/31/22 revealed:<br>-Diagnoses included schizophrenia.<br>-Resident #3 required assistance with bathing and dressing.<br><br>Review of Resident #3's resident register revealed an admission date of 12/31/22.<br><br>Review of Resident #3's record revealed:<br>-Pages 1 and 2 of the care plan had been completed.<br>-Page 3 of the care plan had not been completed or signed.<br><br>Interview with Resident #3 on 03/20/23 at 8:44am revealed he did not need assistance with anything.<br><br>Telephone interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He was responsible for completing care plans.<br>-Resident #3's care plan not being completed was an oversite. | C 236 | | |

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| C 236 | Continued From page 4<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br>_____<br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/21/23 at 10:55am revealed:<br>-He was not responsible for completing care plans.<br>-The Director/Owner was responsible for completing care plans. | C 236 | | |
| C 249 | 10A NCAC 13G .0902(c)(3)(4) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on record review, observation, and interview, the facility failed to ensure the implementation of physician's orders for procedures and treatments for 1 of 3 sampled residents for daily weights. (Resident #2).<br><br>The findings are:<br><br>Review of Resident #2's current FL2 dated 08/25/22 revealed diagnoses included schizophrenia and congestive heart failure (CHF). | C 249 | | |

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| C 249 | Continued From page 5 | C 249 | | |

Review of Resident #2's primary care provider (PCP) after-visit summary dated 02/29/23 revealed:
-Resident #2's blood pressure (BP) was 154/104.
-Resident #2 was being referred to cardiology.
-There was an order to weigh daily. Notify the provider of a weight gain greater than 5 pounds.

Review of Resident #2's February 2023 and April 2023 medication administration record revealed:
-Resident #2's weight was recorded on 02/20/23-02/28/23.
-Resident #2's weight was recorded on 03/01/23-03/08/23.
-There were no weights recorded since 03/08/23.
-Thirteen days had no recorded weights.

Interview with Resident #2 on 03/21/23 at 10:24am revealed:
-He had congestive heart failure (CHF).
-He was supposed to be weighed daily and monitor weight gains and losses.
-He did not weigh daily.
-He did not recall the last time he was weighed.

Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/21/21 at 10:55amrevealed:
-Resident #2 was supposed to be weighed every day.
-A lot was going on early in the morning and by the time he had a chance to check Resident #2 weights, he would get busy with something else.
-He knew it was important to check Resident #2's weight because of his heart condition.

Telephone interview with Resident #2's primary care provider (PCP) on 03/21/23 at 12:39pm revealed:
-She wanted Resident #2 to be weighed daily.

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| C 249 | Continued From page 6<br>-If Resident #2 had a weight gain it was a way of knowing he was getting in trouble with his CHF.<br>-If Resident #2 had gained weight and she was notified, she would tell the medication aide (MA) to administer an extra dose of his "fluid pill."<br>-If Resident #2 was not weighed, she would not know if the resident was getting in trouble with his CHF.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He knew Resident #2 had an order for weights, but he did not recall how often the weights were to be checked.<br>-He expected the SIC/MA to follow the order as written.<br>-He knew the SIC/MA had checked Resident #2's weights, but not every day.<br>-It was an overcite not to check Resident #2's weights as ordered. | C 249 | | |
| C 330 | 10A NCAC 13G .1004(a) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>FOLLOW UP TO A TYPE B VIOLATION<br><br>Based on these findings, the previous Type B | C 330 | | |

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| C 330 | Continued From page 7 | C 330 | | |

violation was abated. Deficient practice continues.

Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 2 of 3 residents, (#1, #2) including a mood stabilizer and an antipsychotic medication (#1) and a mood stabilizer and a medication used to treat edema (puffiness caused by excess fluid trapped in the body's tissues) (#2).

The findings are:

1. Review of Resident #1's current FL2 dated 05/04/22 revealed diagnoses included paranoid schizoaffective disorder, bipolar type.

a. Review of Resident #1's physician order dated 10/10/22 revealed an order for Lithium Carbonate 450mg twice daily (used to stabilize mood).

Review of Resident #1's January 2023 medication administration record (MAR) from 01/11/23-01/31/23 revealed:
-There was an entry for Lithium Carbonate 450mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation that Lithium Carbonate 450mg was administered daily at 8:00am and 8:00pm from 01/11/23-01/31/23.
-There were 42 doses of Lithium documented as administered.

Review of Resident #1's February 2023 medication MAR revealed:
-There was an entry for Lithium Carbonate 450mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Lithium Carbonate

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| C 330 | Continued From page 8 | C 330 | | |

450mg was administered daily at 8:00am and 8:00pm from 02/01/23-02/28/23.
-There were 56 doses of Lithium documented as administered.

Review of Resident #1's March 2023 medication MAR from 03/01/23-03/20/23 revealed:
-There was an entry for Lithium Carbonate 450mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation that Lithium Carbonate 450mg was administered daily at 8:00am and 8:00pm from 03/01/23-03/19/23 and at 9:00am on 03/20/23.
-There were 39 doses of Lithium documented as administered.

Observation of Resident #1's medication on hand on 03/20/23 at 11:30am revealed:
-Sixty tablets of Lithium Carbonate 450mg were dispensed on 01/31/23 and 40 tablets were dispensed on 02/28/23.
-There were 35 tablets remaining in the 01/31/23 dispensing and 40 tablets remaining in the 02/28/23 dispensing.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/20/23 at 12:38pm revealed:
-Resident #1's Lithium Carbonate was dispensed on 01/03/23 (delivered on 01/10/23) and 01/31/23 (delivered on 02/07/23) for 60 tablets each dispense.
-On 02/28/23, 40 tablets of Lithium Carbonate were dispensed for Resident #1 because Resident #1 had a total of 360 tablets that could be dispensed on the prescription and 320 had been dispensed prior to the 40 being dispensed (delivered on 03/07/23) for a total of 360 tablets.

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| C 330 | Continued From page 9<br><br>Based on Resident #1's eMAR documentation, medications dispensed and delivery dates, and medications on hand between 01/11/23-02/28/23, there should have been 23 tablets of Lithium Carbonate available to be administered; seventy-five tablets were available to be administered.<br><br>Telephone interview with a supervisor at a local hospital on 03/21/23 at 9:00am revealed:<br>-She was familiar with Resident #1.<br>-Prescriptions for each medication for Resident #1 were faxed to the requested pharmacy prior to discharge.<br>-Resident #1 would not have been discharged with any medications to take with him to the facility.<br><br>Telephone interview with a pharmacist at the facility's contract pharmacy on 03/21/23 at 3:58pm revealed the main side effects of not receiving Lithium as ordered would be more behavioral issues, such as outbursts and unruly.<br><br>Interview with Resident #1 on 03/21/23 at 9:55am revealed he did not know what medications he took.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/20/21 at 4:03pm revealed:<br>-He was not at the facility when Resident #1 had an altercation with another resident.<br>-Resident #1 had been administered his as needed (PRN) Lorazepam (used for anxiety) more often because the resident was getting up all night and was restless.<br>-Resident #1 came to the facility with medication would be the reason why there were so many tablets remaining. | C 330 | | |

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| C 330 | Continued From page 10<br>-He did not have a record of what medications or how many tablets were brought with Resident #1.<br>-He did not know of any other reason why Resident #1 had extra tablets of Lithium on hand because he knew he had administered the medication delivered correctly.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He was outside when he heard a "ruckus" inside the facility and when he stepped inside the altercation had already stopped.<br>-The story he was told was another resident had been angered by Resident #1's walking, the other resident told him Resident #1 "walked, walked, and walked."<br>-He did not know Resident #1 had extra tablets of Lithium on hand.<br>-Resident #1 came to the facility with medications from the hospital.<br>-He knew Resident #1 had medications from the hospital because he refused to take the resident without medications in case there was a delay in getting medications from the pharmacy.<br>-He did not know who from the hospital provided him with medications for Resident #1.<br>-He expected medications to be administered as ordered.<br>-Resident #1 did not currently have a MH provider but the paperwork had been provided to obtain an appointment.<br><br>Telephone interview with a representative at the MH providers office on 03/21/23 at 12:00pm revealed:<br>-There had been an issue with obtaining consent from Resident #1's legal guardian, but the information had "just" been processed and an appointment would be made for the resident. | C 330 | | |

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| C 330 | Continued From page 11<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br><br>b. Review of Resident #1's physician order dated 10/10/22 revealed an order for Olanzapine 25mg daily (an antipsychotic used to treat mental health conditions).<br><br>Review of Resident #1's January 2023 medication administration record (MAR) from 01/11/23-01/31/23 revealed:<br>-There was an entry for Olanzapine 25mg [take (5) 5mg tablets] once tablet with a scheduled for administration at 8:00pm.<br>-There was documentation Olanzapine 25mg was administered daily at 8:00pm from 01/11/23-01/31/23.<br>-There were 21 doses of Olanzapine documented as administered.<br><br>Review of Resident #1's February 2023 medication MAR revealed:<br>-There was an entry for Olanzapine 25mg [take (5) 5mg tablets] once tablet with a scheduled for administration at 8:00pm.<br>-There was documentation Olanzapine 25mg was administered daily at 8:00pm from 02/01/23-02/28/23.<br>-There were 28 doses of Olanzapine documented as administered.<br><br>Review of Resident #1's March 2023 medication MAR from 03/01/23-03/20/23 revealed:<br>-There was an entry for Olanzapine 25mg [take (5) 5mg tablets] once tablet with a scheduled for administration at 8:00pm.<br>-There was documentation Olanzapine 25mg was administered daily at 8:00pm from 03/01/23-03/19/23. | C 330 | | |

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| C 330 | Continued From page 12<br>-There were 19 doses of Olanzapine documented as administered.<br><br>Observation of Resident #1's medication on hand on 03/20/23 at 11:30am revealed:<br>-Thirty tablets were dispensed on 01/31/23 and 20 tablets were dispensed on 02/28/23.<br>-There were 5 tablets remaining in the 01/31/23 dispensing and 20 tablets remaining in the 02/28/23 dispensing.<br>-Resident #1 had a total of 25 tablets of Olanzapine on hand.<br><br>Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/20/23 at 12:38pm revealed:<br>-Resident #1's Olanzapine was dispensed on 01/03/23 (delivered on 01/10/23) and 01/31/23 (delivered on 02/07/23) for 30 tablets each dispense.<br>-On 02/28/23, only 20 tablets of Olanzapine were dispensed for Resident #1 because Resident #1 had a total of 180 tablets that could be dispensed on the prescription and 160 had been dispensed prior to the 20 being dispensed (delivered on 03/07/23) for a total of 180 tablets.<br><br>Based on Resident #1's eMAR documentation, medications dispensed and delivery dates, and medications on hand between 01/10/23-02/28/23, there should have been 12 tablets of Olanzapine available to be administered; twenty-five tablets were available to be administered.<br><br>Telephone interview with a supervisor at a local hospital on 03/21/23 at 9:00am revealed:<br>-She was familiar with Resident #1.<br>-Prescriptions for each medication for Resident #1 were faxed to the requested pharmacy prior to discharge. | C 330 | | |

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| JONES FAMILY HOME #1 | 2437 EPHESUS CHURCH ROAD SEMORA, NC 27343 |

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| C 330 | Continued From page 13<br>-Resident #1 would not have been discharged with any medications to take with him to the facility.<br><br>Telephone interview with a pharmacist at the facility's contract pharmacy on 03/21/23 at 3:58pm revealed the main side effects of not receiving Olanzapine as ordered would be more behavioral issues, such as outbursts and unruly.<br><br>Interview with Resident #1 on 03/21/23 at 9:55am revealed:<br>-He took medications every day, in the morning and evenings, but did not know what medications or how many tablets.<br>-He felt "fine."<br>-He had a fight with another resident a few weeks ago but the other resident had spit on him first.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/20/21 at 4:03pm revealed:<br>-He was not at the facility when Resident #1 had an altercation with another resident.<br>-Resident #1 had been administered his as needed (PRN) Lorazepam (used for anxiety) more often because the resident was seeing things, getting up all night, and was restless.<br>-Resident #1 came to the facility with medication would be the reason why there were so many tablets remaining.<br>-He did not have a record of what medications or how many tablets were brought with Resident #1.<br>-He did not know of any other reason why Resident #1 had extra tablets of Olanzapine on hand because he knew he had administered the medication delivered correctly.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed: | C 330 | | |

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| C 330 | Continued From page 14<br><br>-He was outside when he heard a "ruckus" inside the facility and when he stepped inside the altercation had already stopped.<br>-The story he was told was another resident had been angered by Resident #1's walking, the other resident told him Resident #1 "walked, walked, and walked."<br>-He did not know Resident #1 had extra tablets of Olanzapine on hand.<br>-Resident #1 came to the facility with medications from the hospital.<br>-He knew Resident #1 had medications from the hospital because he refused to take the resident without medications.<br>-He did not know who from the hospital provided him with medications for Resident #1.<br>-He expected medications to be administered as ordered.<br>-Resident #1 did not currently have a MH provider but the paperwork had been provided to obtain an appointment.<br><br>Telephone interview with a representative at the MH providers office on 03/21/23 at 12:00pm revealed Resident #1 did not currently have a MH provider because there had been an issue with obtaining consent from Resident #1's legal guardian but the information had "just" been processed and an appointment would be made for the resident.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br><br>2. Review of Resident #2's current FL2 dated 08/25/22 revealed diagnoses included schizophrenia and congestive heart failure (CHF).<br><br>a. Review of Resident #2's physician order dated | C 330 | | |

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| C 330 | Continued From page 15<br>10/10/22 revealed an order for Tegretol 200mg twice daily (used as a mood stabilizer).<br><br>Review of Resident #2's January 2023 medication administration record (MAR) from 01/11/23-01/31/23 revealed:<br>-There was an entry for Tegretol 200mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.<br>-There was documentation Tegretol 200mg was administered daily at 8:00am and 8:00pm from 01/11/23-01/31/23.<br>-There were 42 doses of Tegretol 200mg documented as administered.<br><br>Review of Resident #2's February 2023 medication MAR revealed:<br>-There was an entry for Tegretol 200mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.<br>-There was documentation Tegretol 200mg was administered daily at 8:00am and 8:00pm from 02/01/23-02/28/23.<br>-There were 56 doses of Tegretol 200mg documented as administered.<br><br>Review of Resident #2's March 2023 medication MAR from 03/01/23-03/20/23 revealed:<br>-There was an entry for Tegretol 200mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.<br>-There was documentation Tegretol 200mg was administered daily at 8:00am and 8:00pm from 03/01/23-03/19/23 and at 9:00am on 03/20/23.<br>-There were 39 doses of Tegretol 200mg documented as administered.<br><br>Observation of Resident #2's medication on hand on 03/20/23 at 11:30am revealed:<br>-Sixty tablets of Tegretol 200mg were dispensed | C 330 | | |

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| C 330 | Continued From page 16 | C 330 | | |

on 01/31/23 and 40 tablets were dispensed on 02/28/23.
-There were 29 tablets remaining in the 01/31/23 dispensing and 40 tablets remaining in the 02/28/23 dispensing.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/20/23 at 12:38pm revealed:
-Resident #2's Tegretol 200mg was dispensed on 01/03/23 (delivered on 01/10/23) and 01/31/23 (delivered on 02/07/23) for 60 tablets each dispense.
-On 02/28/23, only 40 tablets of Tegretol 200mg were dispensed for Resident #2 because Resident #2 had a total of 360 tablets that could be dispensed on the prescription and 320 had been dispensed prior to the 40 being dispensed (delivered on 03/07/23) for a total of 360 tablets.

Based on Resident #2's eMAR documentation, medications dispensed and delivery dates, and medications on hand between 01/11/23-02/28/23, there should have been 37 tablets of Tegretol available to be administered; seventy tablets were available to be administered.

Telephone interview with a supervisor at a local hospital on 03/21/23 at 9:00am revealed:
-She was familiar with Resident #2.
-Prescriptions for each medication for Resident #2 were faxed to the requested pharmacy prior to discharge.
-Resident #2 would not have been discharged with any medications to take with him to the facility.

Telephone interview with Resident #2's primary care provider (PCP) on 03/21/23 at 12:39pm revealed she was not a mental health provider

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| C 330 | Continued From page 17<br>(MH) but she expected Resident #2's medications to be administered as ordered.<br><br>Interview with Resident #2 on 03/21/23 at 10:24am revealed:<br>-He took medications every day, in the morning and evenings, but did not know what medications or how many tablets.<br>-He had been injured recently when he defended himself from another resident.<br>-He was watching a sports game when the other resident changed the channel on the television, and he asked the resident why he changed the channel, and the resident attacked him.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/20/21 at 4:03pm revealed:<br>-He was not at the facility when Resident #2 had an altercation with another resident.<br>-Resident #2 came to the facility with medication would be the reason why there were so many tablets remaining.<br>-He did not have a record of what medications or how many tablets were brought with Resident #2.<br>-He did not know of any other reason why Resident #2 had extra tablets of Tegretol on hand because he knew he had administered the medication delivered correctly.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He was outside when he heard a "ruckus" inside the facility and when he stepped inside the altercation had already stopped.<br>-The story he was told was Resident #2 had been angered by another residents walking and spit on Resident #2.<br>-He did not know Resident #2 had extra tablets of Tegretol on hand. | C 330 | | |

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-Resident #2 came to the facility with medications from the hospital.
-He knew Resident #2 had medications from the hospital because he refused to take the resident without medications.
-He did not know who from the hospital provided him with medications for Resident #2.
-He expected medications to be administered as ordered.

Attempted telephone interview with Resident #2's MH provider on 03/21/23 at 12:18pm was unsuccessful.

Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.

b. Review of Resident #2's physician order dated 10/10/22 revealed an order for Torsemide twice daily (used to treat fluid retention).

Review of Resident #2's January 2023 medication administration record (MAR) from 01/11/23-01/31/23 revealed:
-There was an entry for Torsemide 20mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Torsemide 20mg was administered daily at 8:00am and 8:00pm from 01/11/23-01/31/23.
-There were 42 doses of Torsemide documented as administered.

Review of Resident #2's February 2023 medication MAR revealed:
-There was an entry for Torsemide 20mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Torsemide 20mg was

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administered daily at 8:00am and 8:00pm from 02/01/23-02/28/23.
-There were 56 doses of Torsemide 20mg documented as administered.

Review of Resident #2's March 2023 medication MAR from 03/01/23-03/20/23 revealed:
-There was an entry for Torsemide 20mg one tablet twice daily scheduled for administration at 8:00am and 8:00pm.
-There was documentation Torsemide 20mg was administered daily at 8:00am and 8:00pm from 03/01/23-03/19/23 and at 9:00am on 03/20/23.
-There were 39 doses of Torsemide 20mg documented as administered.

Observation of Resident #2's medication on hand on 03/20/23 at 11:30am revealed:
-Sixty tablets of Torsemide 20mg were dispensed on 01/31/23 and 40 tablets were dispensed on 02/28/23.
-There were 29 tablets remaining in the 01/31/23 dispensing and 40 tablets remaining in the 02/28/23 dispensing.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/20/23 at 12:38pm revealed:
-Resident #2's Torsemide 20mg was dispensed on 01/03/23 (delivered on 01/10/23) and 01/31/23 (delivered on 02/07/23) for 60 tablets each dispense.
-On 02/28/23, only 40 tablets of Torsemide were dispensed for Resident #2 because Resident #2 had a total of 360 tablets that could be dispensed on the prescription and 320 had been dispensed prior to the 40 being dispensed (delivered on 03/07/23) for a total of 360 tablets.

Based on Resident #2's eMAR documentation,

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medications dispensed and delivery dates, and medications on hand between 01/11/23-02/28/23, there should have been 23 tablets of Torsemide available to be administered; sixty-nine tablets were available to be administered.

Telephone interview with a supervisor at a local hospital on 03/21/23 at 9:00am revealed:
-She was familiar with Resident #2.
-Prescriptions for each medication for Resident #2 were faxed to the requested pharmacy prior to discharge.
-Resident #2 would not have been discharged with any medications to take with him to the facility.

Telephone interview with Resident #2's primary care provider (PCP) on 03/21/23 at 12:39pm revealed:
-Torsemide was a "strong fluid pill."
-She expected Resident #2's Torsemide to be administered twice daily as ordered.
-Resident #2 had congestive heart failure (CHF) and it was important for his body not to get in "fluid overload" and the Torsemide was one way of ensuring this.

Telephone interview with a pharmacist at the facility's contract pharmacy on 03/21/23 at 3:58pm revealed if Torsemide was not administered as ordered the resident could experience a build-up of fluid and an increased blood pressure (BP).

Review of Resident #2's PCP after-visit summary dated 02/24/23 revealed Resident #2 had a BP of 154/104 and was being referred to a cardiologist.

Interview with Resident #2 on 03/21/23 at 10:24am revealed:

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| C 330 | Continued From page 21<br>-He took medications every day, in the morning and evenings, but did not know what medications or how many tablets.<br>-He sometimes had fluid buildup in his lower legs, but he had not had that happen since November 2022.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/20/21 at 4:03pm revealed:<br>-Resident #2 came to the facility with medication would be the reason why there were so many tablets remaining.<br>-He did not have a record of what medications or how many tablets were brought with Resident #2.<br>-He did not know of any other reason why Resident #2 had extra tablets of Torsemide on hand because he knew he had administered the medication delivered correctly.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He did not know Resident #2 had extra tablets of Torsemide on hand.<br>-Resident #2 came to the facility with medications from the hospital.<br>-He knew Resident #2 had medications from the hospital because he refused to take the resident without medications in case there was a delay in obtaining the medications from the pharmacy.<br>-He did not know who from the hospital provided him with medications for Resident #2.<br>-He expected medications to be administered as ordered.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful. | C 330 | | |

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| C 335 | 10A NCAC 13G .1004 (f) (1-4) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br><br>(f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage:<br>(1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container;<br>(2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name;<br>(3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and<br>(4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.<br><br>This Rule is not met as evidenced by: | C 335 | | |

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| C 335 | Continued From page 23<br><br>Based on observations and interviews the facility failed to ensure medications prepared for administration in advance were kept in a sealed container that identified the name and strength of each medication prepared, identified up to the point of administration, and protected from contamination for the 6 residents who resided in the facility.<br><br>The findings are:<br><br>Observation of the kitchen on 03/20/23 at 8:34am revealed:<br>-The medication aide (MA)/ Supervisor in Charge (SIC) was holding 6 clear plastic medication cups, each cup stacked directly on another medication cup.<br>-There were multiple tablets in each of the clear medication cups.<br>-The MA/SIC handed the medication cup to the residents who then walked to the kitchen sink, used a cup to get water from the faucet, took their medications, and returned the cups to the MA/SIC; the cups were then set inside a kitchen cabinet.<br>-The cups were not labeled with the names of the residents to which the medications were to be administered.<br>-The cups were not labeled with the medication contained in each cup.<br>-The medication cups were not covered or sealed and therefore the medications inside the cups were not protected from contamination.<br><br>Interview with 6 residents on 03/20/23 between 8:38am-8:54am revealed:<br>-They were administered their medications from cups the MA/SIC gave them.<br>-They had not looked at the cups to see if the cups were labeled with their names or | C 335 | | |

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| C 335 | Continued From page 24<br>medications.<br>-They usually took their medications, "just like today."<br><br>Interview with the MA/SIC on 03/20/23 at 8:34am revealed:<br>-This was how he always administered medications.<br>-He did not need to label the cups with the resident's names because he knew which medication cup went to which resident.<br><br>Interview with the MA/SIC on 03/21/23 at 10:05am revealed:<br>-Each resident had an assigned drawer that contained their medications.<br>-He prepared medications one drawer at a time.<br>-He opened the drawer, read the label on the punch card and punched the tablet into a cup.<br>-He sat the cups in a line on top of the cabinet and when he got to the end of the line he stacked the cups in order.<br>-He then handed the cups out in the order he knew they went to, plus he knew the medications each resident took.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-The MA/SIC should not be putting medications in unlabeled cups because the medications could get mixed up.<br>-He expected the MA/SIC to administer medications one resident at a time.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful. | C 335 | | |

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| JONES FAMILY HOME #1 | 2437 EPHESUS CHURCH ROAD SEMORA, NC 27343 |

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| C 341 | Continued From page 25 | C 341 | | |
| C 341 | 10A NCAC 13G .1004 (i) Medication Administration<br><br>10A NCAC 13G .1004 Medication Administration<br><br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure the documentation on the medication administration records (MARs) included the initials of the medication aide (MA) who administered the medication to three residents.<br><br>The findings are:<br><br>Observation of the kitchen on 03/20/23 at 8:34am revealed:<br>-The medication aide (MA)/ Supervisor in Charge (SIC) was holding 6 clear plastic medication cups, each cup stacked directly on another medication cup.<br>-There were multiple tablets in each of the clear medication cups.<br>-The MA/SIC handed the medication cup to the residents who then walked to the kitchen sink, used a cup to get water from the faucet, took their medications, and returned the cups to the MA/SIC; the cups were then set inside a kitchen | C 341 | | |

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| C 341 | Continued From page 26<br>cabinet.<br>-The medication administration records were not present during the medication pass.<br><br>Interview with the MA/SIC on 03/21/23 at 10:55am revealed:<br>-He signed the MARs as he took the medication out of the packet.<br>-He did not chart each resident's medications after he observed the resident take the medication.<br>-If a resident refused a medication he would go back to the MAR and circle his initials and document the refusal on the back of the MAR.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed he expected the MA/SIC to administer medications one resident at a time and document after each administration.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful. | C 341 | | |
| C 367 | 10A NCAC 13G .1008(a) Controlled Substances<br><br>10A NCAC 13G .1008 Controlled Substances<br>(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.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the | C 367 | | |

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| C 367 | Continued From page 27 | C 367 | | |

receipt, administration, and disposition of controlled substances was maintained for 3 of 3 sampled residents (#1, #2 and #3) with physician orders for controlled medication.

The findings are:

1. Review of Resident #3's current FL2 dated 10/31/22 revealed diagnoses schizophrenia.

Review of Resident #3's physician order dated 10/31/22 revealed an order for Lorazepam (used for anxiety) 0.5mg tablet twice daily.

Review of Resident #3's March 2023 medication administration record (MAR) from 03/05/23-03/20/23 revealed:
-There was an entry for Lorazepam 0.5mg tablet with a scheduled administration time of 8:00am and 8:00pm.
-Lorazepam was documented as administered at 8:00pm on 03/05/23 and twice a day 03/19/23 and the 8:00am dose on 03/20/23.
-There were 24 doses documented as administered.

Observation of Resident #3's medications on hand on 03/20/23 at 9:02am revealed there was a punch card of thirty Lorazepam 0.5mg dispensed on 03/01/23 the card was labeled 2 of 2; 2 tablets remained in the card.

Review of Resident #3's March 2023 controlled substance count sheets (CSCS) revealed:
-The first entry was dated 03/05/23 at 8:00pm.
-The last entry was dated 03/17/23 at 8:00am with a remaining dose of 6 tablets.
-There was no documentation for the 03/17/23 8:00pm dose, the 03/18/23-03/19/23 8:00am and 8:00pm dose, or the 03/20/23 8:00am dose.

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| C 367 | Continued From page 28<br>-There were 24 doses documented as administered.<br><br>Review of Resident #3's March 2023 MAR compared to Resident #1's CSCS and medications on hand revealed:<br>-There were 6 doses that were documented on the MAR but were not documented on the CSCS and 2 tablets were remaining in the punch card.<br>-If the 6 doses that were documented on the MAR had been administered there would have been no tablets remaining in the punch card dispensed on 03/01/23 for 30 tablets.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/20/21 at 9:10am revealed:<br>-He had administered Resident #3's Lorazepam at 8:00am and 8:00pm on 03/17-03/20 but forgot to document all of the administrations on the CSCS.<br>-He documented the Lorazepam administration on the MAR.<br>-He did not know why there were 2 tablets available to be administered when there should be 0 based on the documentation on the MAR.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br><br>Refer to the interview with the Director/Owner on 03/21/23 at 1:15pm.<br><br>2. Review of Resident #1's current FL2 dated 05/04/22 revealed diagnoses included paranoid schizoaffective disorder, bipolar type.<br><br>Review of Resident #1's physician order dated 10/10/22 revealed an order for Lorazepam (used | C 367 | | |

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| C 367 | Continued From page 29 | C 367 | | |

for anxiety) 1mg tablet every six hours as needed for anxiety.

Review of Resident #1's January 2023 medication administration record (MAR) from 01/11/23-01/31/23 revealed:
-There was an entry for Lorazepam 1mg tablet every six hours as needed for anxiety.
-On the front of the MAR there was documentation Lorazepam was administered once a day on 01/01/23-01/02/23, 01/06/23, 01/08/23-01/27/23, and 01/30/23.
-There were 24 doses of Lorazepam documented as administered on the front of the MAR.
-On the back of the MAR Lorazepam 1mg was documented as administered once on 01/03/23, 01/06/23, 01/08/23, 01/09/23, and 01/10/23, and twice on 01/11/23-01/17/23.
-There were 19 doses of Lorazepam documented as administered on the back of the MAR.
-There were no doses documented on the back of the MAR or other forms to show the time of the administration, reasons, or effectiveness of the medication from 01/18/23-01/31/23.

Review of Resident #1's October 2022 controlled substance count sheets (CSCS) for 60 tablets of Lorazepam 0.5mg dispensed on 10/10/22 revealed:
-The first entry for January 2023 was on 01/02/23 and 18 doses were remaining.
-The last entry on the CSCS was on 01/09/23 and 15 doses were remaining.
-There was no other documentation on the CSCS sheet dated October 2022.

Review of Resident #1's CSCS for 60 tablets dispensed on 01/03/23 revealed:
-The first dose documented as administered began on 01/10/23 with 30 tablets.

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| C 367 | Continued From page 30<br>-The last dose documented as administered was on 01/25/23 with no remaining doses.<br><br>Review of Resident #1's CSCS for 60 tablets dispensed on 12/05/22 revealed:<br>-The first dose documented as administered began on 01/26/23 with 30 tablets.<br>-The last dose documented for January 2023 was on 01/31/23 with 23 doses remaining.<br><br>Review of Resident #1's January 2023 eMAR compared to Resident #1's CSCS revealed:<br>-There were 24 doses documented as administered on the front of the January MAR.<br>-There were 19 doses of Lorazepam documented as administered on the back of the MAR.<br>-There was a total of 42 doses of Lorazepam documented on multiple CSCS sheets.<br>-Examples of discrepancies included on 01/11/23 there was an 8:00am and 8:00pm dose of Lorazepam documented on the back of the MAR and there was only an 8:00pm dose documented on the CSCS.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/20/21 at 4:03pm revealed:<br>-He documented on the front of the MAR to indicate the medication was administered that day.<br>-He did not know there should be documentation on the front of the MAR every time the medication was administered.<br>-He did document the administrations on the back with the time, the reason, and effectiveness but ran out of room to document after the 19th entry.<br>-He did not think about documenting on the back of other pages in the MAR because the residents usually had only one page of medications in the MAR. | C 367 | | |

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| C 367 | Continued From page 31<br>-He did not know why there was a missed dose not documented on the CSCS "here and there."<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br><br>Refer to the interview with the Director/Owner on 03/21/23 at 1:15pm.<br><br>3. Review of Resident #2's current FL2 dated 08/25/22 revealed diagnoses included schizophrenia and congestive heart failure (CHF).<br><br>Review of Resident #2's physician order dated 10/10/22 revealed an order for Clonazepam 0.5mg (used for anxiety) tablet twice daily as needed for anxiety.<br><br>Review of Resident #2's March 2023 medication administration record (MAR) from 03/01/23-03/20/23 revealed:<br>-There was an entry for Clonazepam 0.5mg twice daily as needed for anxiety.<br>-On the front of the MAR there was documentation Clonazepam was administered once a day on 03/01/23-03/17/23 and 03/19/23-03/20/23.<br>-On the back of the MAR Clonazepam 0.5mg was documented as administered twice a day on 03/01/23 and only at 8:00pm on 03/02/23 and 8:00am on 03/03/23, 03/04/23 and 03/05/23.<br>-There was documentation Clonazepam 0.5mg was administered twice a day from 03/06/23-03/11/23.<br>-There were no doses documented on the back of the MAR or other forms to show the time of the administration, reasons, or effectiveness of the medication from 03/12/23-03/20/23. | C 367 | | |

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| C 367 | Continued From page 32<br><br>Review of Resident #2's controlled substance count sheets (CSCS) revealed:<br>-Sixty tablets of Clonazepam 0.5mg were dispensed on 01/31/23 revealed:<br>-The first entry for March 2023 was on 03/01/23 and 24 doses were remaining.<br>-The last entry on the CSCS was on 03/15/23 and 0 doses were remaining.<br>-Sixty tablets of Clonazepam 0.5mg were dispensed on 11/08/23 and the first entry on the CSCS sheet was dated 03/16/23 at 8:00pm.<br>-The last entry on the CSCS was on 03/20/23 and 26 doses were remaining.<br><br>Review of Resident #2's March 2023 eMAR compared to Resident #2's CSCS revealed:<br>-There was only 1 dose of Clonazepam 0.5mg documented as administered on the front of the MAR on 03/02/23.<br>-There were 2 doses of Clonazepam 0.5mg documented as administered on 03/02/23 on the back of the MAR.<br>-There was only 1 dose of Clonazepam 0.5mg documented as administered on the CSCS sheet on 03/02/23.<br><br>Observation of Resident #3's medications on hand on 03/20/23 at 11:00am revealed:<br>-Sixty tablets of Clonazepam 0.5mg were dispensed on 11/08/22; twenty-six tablets were remaining.<br>-Sixty tablets of Clonazepam 0.5mg were dispensed on 02/28/22; sixty tablets were remaining.<br>-Sixty tablets of Clonazepam 0.5mg were dispensed on 01/31/23; thirty tablets were remaining.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) | C 367 | | |

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| C 367 | Continued From page 33<br>on 03/20/21 at 4:03pm revealed:<br>-He documented on the front of the MAR to indicate the medication was administered that day.<br>-He did not know there should be documentation on the front of the MAR every time the medication was administered.<br>-He did document the administrations on the back with the time, the reason, and effectiveness but ran out of room to document after the 19th entry.<br>-He did not think about documenting on the back of other pages in the MAR because the residents usually had only one page of medications in the MAR.<br>-He did not know why there was a missed dose not documented on the CSCS "here and there."<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful.<br><br>Refer to the interview with the Director/Owner on 03/21/23 at 1:15pm.<br>_____<br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He had not audited the residents' MARs and CSCS.<br>-He expected all controls administered to be documented correctly on the front of the MAR, the back of the MAR, and the CSCS; documentation on all 3 should match. | C 367 | | |
| C 444 | 10A NCAC 13G .1213 Reporting Of Accidents And Incidents<br><br>10A NCAC 13G .1213 Reporting of Accidents and Incidents | C 444 | | |

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| C 444 | Continued From page 34<br>(a) A family care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency evaluation, hospitalization, or medical treatment other than first aid.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure an incident and accident form was completed and sent to the Department of Social Services (DSS) within 48 hours for 1 of 1 sampled resident (#2) who had an altercation with another resident and was transported to the local emergency department after complaining of head pain.<br><br>The findings are:<br><br>Review of Resident #2's current FL2 dated 08/25/22 revealed diagnoses included schizophrenia and congestive heart failure (CHF).<br><br>Review of a hospital discharge summary for Resident #2 dated 02/12/23 revealed Resident #2 was seen at the emergency department (ED) for an acute cervical strain, head injury, and facial contusion.<br><br>Telephone interview with a representative at the local Department of Social Services on 03/21/23 at 8:57am revealed she had not received an incident report for any incidents at the facility in February 2023.<br><br>Interview with Resident #2 on 03/21/23 at 9:55am revealed: | C 444 | | |

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| C 444 | Continued From page 35<br>-He had been injured recently when he defended himself from another resident.<br>-He was watching the super bowl when Resident #2 changed the channel on the television, and he asked the resident why he changed the channel, and the resident attacked him.<br>-He hurt his neck and head and he had a scratch on his nose that was bleeding.<br><br>Interview with the Supervisor-in-Charge/medication aide (SIC/MA) on 03/20/21 at 4:03pm revealed he was not at the facility when Resident #2 had an altercation with another resident.<br><br>Interview with the Director/Owner on 03/21/23 at 1:15pm revealed:<br>-He was outside when he heard a "ruckus" inside the facility and when he stepped inside the altercation had already stopped.<br>-The story he was told was Resident #2 had been angered by another resident walking and then the resident spit on the other resident.<br>-A resident called 911.<br>-Resident #2 complained his head hurt.<br>-He completed an incident report, but he did not know he needed to send it to DSS.<br>-He thought he only needed to send the incident report if the resident was admitted to the hospital.<br><br>Attempted telephone interview with the Administrator on 03/21/23 at 2:57pm was unsuccessful. | C 444 | | |