STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl035033	A. BUILDING: _____ B. WING _____	R 05/09/2023

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HEART TO HEART FAMILY CARE HOME	131 HUNTINGTON RD LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure section conducted an annual and follow-up survey on May 9, 2023.	C 000		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure therapeutic diets were served as ordered for 3 of 3 sampled residents with diet orders for 1800 calories (#1, #3), and low sodium (#2). The findings are: 1. Review of the 1800 calorie therapeutic menu for 05/09/22 revealed: -The morning snack included ½ cup of vegetable juice and 12 crackers. -The lunch meal included 3 ounces of chicken livers, 2/3 cup of rice, ½ cup green beans, 1 roll, ½ cup ice cream, 1 cup of sugar free tea and 1 cup of water. -The afternoon snack included 1 tablespoon of peanut butter, 6 crackers, and ½ cup vegetable juice. -The evening meal included 1 cup beef vegetable soup, 2 tablespoons peanut butter, ½ sandwich,	C 284		

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½ cup of pears, 1 cup of water, and 1 cup of sugar free tea.

a. Review of Resident #1's current FL-2 dated 04/03/23 revealed:
-Diagnoses included schizophrenia disorder and diabetes mellitus.
-There was an order for an 1800 calories diet.

Review of the therapeutic diet list posted in the kitchen on 05/09/23 at 8:31am revealed Resident #1 was to be served an 1800 calories diet.

Observation of the snack served on 05/09/23 at 9:45am revealed:
-Resident #1 was served 3 "nabs" and a cup of water.
-Resident #1 was given 3 additional nabs upon request.

Observation of the lunch meal on 05/09/23 at 12:04pm revealed:
-Resident #1 was served turkey sausage cut into quarter-sized pieces, a cup of rice, a cup of broccoli, and a cup of water.
-Resident #1 was served 15 pieces of turkey sausage.
-Resident #1 ate 100% of his meal.

Observation of the snack served on 05/09/23 at 2:45pm revealed resident #1 was served 2 "nabs" and fruit punch.

Observation of the dinner meal on 05/09/23 at 5:00pm revealed Resident #1 was served a bowl of vegetable soup, a toasted English muffin, pears, peanut butter, and a cup of fruit juice.

Interview with Resident #1 on 03/22/23 at 8:30 am revealed he was a diabetic and he was on an

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C 284	Continued From page 2 1800 calories diet. Interview with a personal care aide (PCA) on 05/09/23 at 9:39am and 1:10pm revealed: -Resident #1 was on an 1800 calorie diet. -She gave Resident #1 3 additional "nabs" at snack this morning because he asked for more. -She did not have any vegetable juice to serve Resident #1 at snack this morning. -There was no ice cream, roll, or sugar free juice to serve Resident #1 at lunch today. -The food and drink needed to serve Resident #1 was not always in the facility and available. Interview with another PCA on 05/09/23 at 4:00pm revealed: -She referred to the therapeutic menu when preparing the meal. -She served Resident #1 fruit punch and 2 "nabs for afternoon snack and fruit punch for the dinner meal. -There was no sugar-free juice available to serve in the facility. -The sugar-free drink needed to serve the therapeutic diet was not always available in the facility. Interview with the Administrator on 05/09/23 at 4:45pm revealed: -She knew Resident #1 had an order for an 1800 calories diet. -She knew Resident #1 needed sugar free condiments, juice, and snacks. -She knew Resident #1 was given juice with sugar for afternoon snack and the dinner meal today. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 05/09/23 at 3:50pm was unsuccessful.	C 284		

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C 284	Continued From page 3 Refer to the interview with a PCA on 05/09/23 at 9:39am and 1:10pm. Refer to the interview with the Administrator on 05/09/23 at 4:45pm. b. Review of Resident #3's current FL-2 dated 03/29/23 revealed: -Diagnosis included arthritis, hypertension, anxiety, anemia, hyperlipidemia, and diabetes mellitus. -There was an order for a diabetic diet. Review of the therapeutic diet list posted in the kitchen on 05/09/23 at 8:31am revealed Resident #3 was to be served an 1800 calories diet. Observation of the snack served on 05/09/23 at 9:45am revealed Resident #3 was served 3 "nabs" and a cup of water. Observation of the lunch meal on 05/09/23 at 12:04pm revealed: -Resident #3 was served turkey sausage cut into quarter-sized pieces, a cup of rice, a cup of broccoli, and a cup of water. -Resident #3 was served 15 pieces of turkey sausage. -Resident #3 ate 50% of his meal. Observation of the dinner meal on 05/09/23 at 5:00pm revealed Resident #3 was served a bowl of vegetable soup, a toasted English muffin, pears, peanut butter, and a cup of fruit juice. Interview with Resident #3 on 03/22/23 at 8:30 am revealed she was on a diabetic diet. Interview with a personal care aide (PCA) on	C 284		

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C 284	Continued From page 4 05/09/23 at 9:39am and 1:10pm revealed: -Resident #3 was on an 1800 calories diet. -She did not have any vegetable juice to serve Resident #3 at snack this morning. -There was no ice cream, roll, or sugar free juice to serve Resident #3 at lunch today. -The food and drink needed to serve Resident #3 was not always in the facility and available. Interview with another PCA on 05/09/23 at 4:00pm revealed: -She referred to the therapeutic menu when preparing the meal. -She served Resident #3 fruit punch and 2 "nabs for afternoon snack and fruit punch for the dinner meal. -There was no sugar-free juice available to serve in the facility. -The sugar-free drink needed to serve the therapeutic diet was not always available in the facility. Interview with the Administrator on 05/09/23 at 4:45pm revealed: -She knew Resident #3 had an order for an 1800 ADA diet. -She knew Resident #3 needed sugar free condiments, juice, and snacks. -She knew Resident #3 was given juice with sugar for snack this afternoon and the dinner meal, today. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 05/09/23 at 3:50pm was unsuccessful. Refer to the interview with a PCA on 05/09/23 at 9:39am and 1:10pm. Refer to the interview with the Administrator on	C 284		

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C 284	Continued From page 5 05/09/23 at 4:45pm. 2. Review of the low sodium therapeutic menu for 05/09/22 revealed: -The morning snack included 1 cup of fresh fruit, ½ cup of vegetable juice, and 6 low sodium crackers. -The lunch meal included 3 ounces of chicken livers, 1/2 cup low sodium of rice, ½ cup green beans, 1 roll, ½ cup ice cream, 1 cup of tea and 1 cup of water. -The afternoon snack included 1 tablespoon of peanut butter, 6 low sodium crackers, and 1 cup of milk. -The evening meal included 1 cup low sodium beef vegetable soup, 2 tablespoons peanut butter, sandwich, ½ cup of pears, and 1 cup of water. Review of Resident #2's current FL-2 dated 08/29/22 revealed: -Diagnoses included schizophrenia, hyperlipidemia, insomnia, hypertension, and intellectual disability. -There was an order for a low sodium diet. Review of the therapeutic diet list posted in the kitchen on 05/09/23 at 8:31am revealed Resident #2 was to be served a low sodium diet. Observation of the snack served on 05/09/23 at 9:45am revealed Resident #2 was served 3 "nabs" and a cup of water. Observation of the lunch meal on 05/09/23 at 12:04pm revealed: -Resident #2 was served turkey sausage cut into quarter-sized pieces, a cup of rice, a cup of broccoli, and a cup of water. -Resident #2 was served 15 pieces of turkey	C 284		

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sausage.
-Resident #2 ate 100% of his meal.

Observation of the snack served on 05/09/23 at 2:45pm revealed resident #2 was served 2 "nabs" and fruit punch.

Observation of the dinner meal on 05/09/23 at 5:00pm revealed Resident #2 was served a bowl of vegetable soup, a toasted English muffin, pears, peanut butter, and a cup of fruit juice.

Interview with Resident #2 on 05/09/23 at 9:30 am revealed:
-He had to watch his salt intake because he had high blood pressure.
-His Primary Care Provider wanted him on a low sodium diet.
-He did not add salt to his food.

Interview with a personal care aide (PCA) on 05/09/23 at 9:39am and 1:10pm revealed:
-Resident #2 was on a low sodium diet.
-She did not have any fresh fruit or low sodium crackers to serve Resident #3 at snack this morning.
-She did not have any low sodium rice to serve at the lunch meal.

Interview with the Administrator on 05/09/23 at 4:45pm revealed:
-She knew Resident #2 had an order for a low sodium diet.
-She had purchased low sodium crackers and low sodium rice as listed on the menu for today.
-The staff would let her know what foods were needed in the facility.

Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 05/09/23 at

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C 284	Continued From page 7 3:50pm was unsuccessful. Refer to the interview with a PCA on 05/09/23 at 9:39am and 1:10pm. Refer to the interview with the Administrator on 05/09/23 at 4:45pm. _____ Interview with a personal care aide (PCA) on 05/09/23 at 9:39am and 1:10pm revealed: -She knew the therapeutic menus were in the notebook on the kitchen counter. -She referred to the therapeutic menus sometimes. -She prepared meals based on the food that was in the facility sometimes. -She would "eye-ball" the serving size when plating the meal. -She did not always refer to the menu to reference the serving size. -She should refer to the therapeutic menu with each therapeutic meal. Interview with the Administrator on 05/09/23 at 4:45pm revealed: -She knew there were no sugar free condiments or snacks or low sodium foods in the facility. -There was no excuse for the facility to be out of sugar free condiments and snacks, or low sodium foods. -She was going to the grocery store today to purchase sugar free condiments and snacks and low sodium foods. -She had some food delivered today but the sugar free and low sodium food was purchased at a different store.	C 284		
C 330	10A NCAC 13G .1004(a) Medication Administration	C 330		

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C 330	Continued From page 8 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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 sampled residents (#1, #2, and #3) related to a medication for depression and anxiety and a medication to help control muscle movement (#1); a medication for depression and a medication to lower cholesterol (#2); and a medication for pain and inflammation (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 04/03/23 revealed diagnoses included schizophrenia disorder and diabetes mellitus. a. Review of Resident #1's current FL-2 dated 04/03/23 revealed: -There were no medications listed on the FL-2. -There was a hand-written entry that read "see attached". -The attachment was a list of Resident #1's current medication list. -There was an order for trazodone 100 mg (used for depression and anxiety) at night. Review of Resident #1's March 2023 medication	C 330		

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C 330	Continued From page 9	C 330		

administration record (MAR) revealed:
-There was an entry for trazodone 100mg at night with a scheduled administration time of 8:00pm.
-There was documentation trazodone was administered each night from 03/01/23 to 03/31/23.

Review of Resident #1's April 2023 MAR revealed:
-There was an entry for trazodone 100mg at night with a scheduled administration time of 8:00pm.
-There was documentation trazodone was administered each night from 04/01/23 to 04/30/23.

Review of Resident #1's May 2023 MAR from 05/01/23 to 05/08/23 revealed:
-There was an entry for trazodone 100mg at night with a scheduled administration time of 8:00pm.
-There was documentation trazodone was administered each night from 05/01/23 to 05/08/23.

Observation of Resident #1's medications on hand on 05/09/23 at 1:10pm revealed:
-There was a blister pack with 16 of 21 trazodone dispensed on 12/05/22 available for administration.
-There was a blister pack with 30 of 30 trazodone dispensed on 12/20/22 available for administration.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/09/23 at 3:11pm and 4:45pm revealed:
-The pharmacy had an order for trazodone 100mg at night.
-The pharmacy dispensed 21 tablets of trazodone 100mg on 12/05/22 and 30 tablets of trazodone 100mg on 12/20/23.

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C 330	Continued From page 10 -Resident #1 had an order for trazodone 100mg as needed in November 2022, however the order was not filled. -Medications that are ordered "as needed" must be requested by the facility to be filled. -The facility did not make a request for trazodone 100mg to be filled. Review of eMAR documentation, medications dispensed and medications on hand between 12/05/22 and 05/08/23 revealed: -There were 21 trazodone 100mg dispensed on 12/05/22 available for administration from 12/06/22 to 12/27/22. -There were 16 of 21 trazodone remaining from 12/05/22. -There were 30 trazodone 100mg dispensed on 12/20/22 available for administration from 12/28/22 to 01/26/23. -There were 30 of 30 trazodone remaining from 12/20/22. -There was documentation trazadone 100mg was administered every night from 01/27/23 to 05/08/23 for a total of 102, when there had been no trazodone dispensed from January 2023 to May 2023 and still had 46 of 51 tablets remaining that were dispensed in December 2022. Interview with the Administration/Medication Aide (MA) on 05/09/23 at 4:45pm revealed: -She administered Resident #1 trazodone 100mg each night. -Resident #1 had an "as needed" order in 2022. -The trazodone "as needed" order was for 2 months, November and December 2022. -Resident #1 had some trazodone "as needed" tablets remaining so they were administered. -She thought Resident #1 had "as needed" trazodone remaining from November and December 2022.	C 330		

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C 330	Continued From page 11 -She did not know why trazodone 100mg was being administered from blister packs dispensed on 12/05/22 and 12/20/22. Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 05/09/23 at 3:50pm was unsuccessful. Refer to the Administrator's interview dated 05/09/23 at 4:45pm. b. Review of Resident #1's current FL-2 dated 04/04/23 revealed: -There were no medications listed on the FL-2. -There was a hand-written entry that read "see attached". -The attachment was a list of Resident #1's current medication list. -There was an order for benztropine 0.5mg (used to help control muscle movement) twice daily. Review of Resident #1's March 2023 medication administration record (MAR) revealed: -There was an entry for benztropine 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation benztropine was administered twice daily from 03/01/23 to 03/31/23. Review of Resident #1's April 2023 MAR revealed: -There was an entry for benztropine 1mg twice daily with a scheduled administration time of 8:00pm. -There was documentation benztropine was administered twice daily from 04/01/23 to 04/30/23. Review of Resident #1's May 2023 MAR from	C 330		

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C 330	Continued From page 12 05/01/23 to 05/09/23 revealed: -There was an entry for benztropine 1mg twice daily with a scheduled administration time of 8:00pm. -There was documentation benztropine was administered twice daily from 05/01/23 to 05/08/23. Observation of Resident #1's medications on hand on 05/09/23 at 1:10pm revealed: -There was a blister pack with 3 of 60 benztropine dispensed on 02/15/23 available for administration. -There was a blister pack with 7 of 60 benztropine dispensed on 03/20/23 available for administration. -There were two cards with 30 of 30 (60 tablets) benztropine dispensed on 05/03/23 available for administration. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/09/23 at 3:11pm revealed: -The pharmacy had an order for benztropine 1mg twice daily dated 02/14/23. -The pharmacy dispensed 60 tablets of benztropine 1mg on 02/15/23, 03/20/23 and 05/03/23. -The pharmacy did not receive an order to decrease benztropine to 0.5mg twice daily. -The pharmacy did not receive a copy of the FL-2 and the attached list of medications dated 04/03/23. -Resident #1 did have an order for benztropine 0.5mg twice daily, however it was discontinued on 02/14/23 when the new order for benztropine 1mg was received. Review of eMAR documentation, medications dispensed and medications on hand between	C 330		

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C 330	Continued From page 13 02/14/23 and 05/08/23 revealed: -There were 60 benztropine 1mg dispensed on 02/15/23 available for administration from 02/16/23 to 03/17/23. -There were 3 of 60 benztropine remaining from 02/15/23. -There were 60 benztropine 1mg dispensed on 03/20/23 available for administration from 03/21/23 to 04/19/23. -There were 7 of 60 benztropine remaining from 03/20/23. -There were 60 benztropine 1mg dispensed on 05/03/23 available for administration from 05/04/23 to 05/08/23. -There were 60 benztropine remaining from 05/03/23 -There was documentation benztropine 100mg was administered twice daily from 03/21/23 to 05/08/23, when there were 3 of 60 benztropine tablets remaining from dispensing dated 02/15/23 when there should have been zero, there were 7 of 60 benztropine tablets remaining from dispensing dated 03/20/23 when there should have been zero, there would have been no benztropine available to administer from 04/20/23 to 05/03/23, and there were 60 benztropine 1mg remaining when there should have been 50. Interview with the Administrator/Medication Aide (MA) on 05/09/23 at 4:45pm revealed: -Resident #1 was ordered benztropine 1mg twice daily. -She administered benztropine 1mg to Resident #1 as ordered. -She did not know why there was no benztropine dispensed in April 2023. -She did not know why there was extra benztropine on hand for administration. Attempted telephone interview with Resident #3's	C 330		

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Primary Care Provider (PCP) on 05/09/23 at 3:50pm was unsuccessful.

Refer to the Administrators interview date 05/09/23 at 4:45pm.

2. Review of Resident #2's current FL-2 dated 08/29/22 revealed diagnosis included schizophrenia, hyperlipidemia, insomnia, hypertension, and intellectual disability.

a. Review of Resident #2's current FL-2 dated 08/29/22 revealed there was an order for venlafaxine 75 mg daily.

Review of Resident #2's April 2023 medication administration record (MAR) from 04/17/23 to 05/09/23 revealed:
-There was an entry for venlafaxine 75mg daily with a scheduled administration time of 8:00am.
-There was documentation venlafaxine was administered daily from 04/01/23 to 04/30/23.

Review of Resident #2's May 2023 MAR from 05/01/23 to 05/09/23 revealed:
-There was an entry for venlafaxine 75mg daily with a scheduled administration time of 8:00am.
-There was documentation venlafaxine was administered daily from 05/01/23 to 05/09/23.

Observation of Resident #2's medications on hand on 05/09/23 at 1:56pm revealed there was no venlafaxine 75mg available for administration.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/09/23 at 3:11pm revealed:
-The pharmacy had an order for venlafaxine 75mg daily.
-The pharmacy dispensed 30 tablets of

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venlafaxine 75mg on 4/17/23.
-The facility should have enough venlafaxine 75mg to last until 05/17/23.

Interview with the Administration on 05/09/23 at 4:45pm revealed:
-She thought she gave Resident #2 venlafaxine 75mg this morning.
-She may have given Resident #2 the last venlafaxine in the blister pack.
-She did not know the pharmacy dispensed 30 tablets of venlafaxine on 4/17/23, and there should still be some available for administration.
-She did not know where the venlafaxine was.

Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 05/09/23 at 3:50pm was unsuccessful.

Refer to the Administrators interview date 05/09/23 at 4:45pm.

b. Review of Resident #2's current FL-2 dated 08/29/22 revealed there was an order for gemfibrozil 600mg twice daily.

Review of Resident #2's March 2023 medication administration record (MAR) revealed:
-There was an entry for gemfibrozil 600mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was no documentation gemfibrozil 600mg was administered twice daily from 03/01/23 to 03/31/23.
-There was a hand-written entry next to the entry for gemfibrozil 600mg twice daily that read "discontinued."

Review of Resident #2's April 2023 MAR revealed:

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C 330	Continued From page 16 -There was an entry for gemfibrozil 600mg twice daily with a scheduled administration time of 8:00am 8:00pm. -There was no documentation gemfibrozil 600mg was administered daily from 04/01/23 to 04/30/23. -There was a hand-written entry next to the entry for gemfibrozil 600mg twice daily that read "discontinued." Review of Resident #2's May 2023 MAR from 05/01/23 to 05/09/23 revealed: -There was an entry for gemfibrozil 600mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was no documentation gemfibrozil 600mg was administered twice daily from 05/01/23 to 05/09/23. -There was a hand-written entry next to the entry for gemfibrozil 600mg twice daily that read "discontinued." Observation of Resident #2's medications on hand on 05/09/23 at 1:56pm revealed: -There was a blister pack with 15 of 30 gemfibrozil 600mg dispensed on 04/14/23 available for administration. -The prescription label had "PM" written with a black marker. -There was a second blister pack with 16 of 30 gemfibrozil 600mg dispensed on 04/14/23 available for administration. -The prescription label had "AM" written with a black marker. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/09/23 at 3:11pm revealed: -The pharmacy had an order for gemfibrozil 600mg twice daily.	C 330		

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C 330	Continued From page 17 -The pharmacy dispensed 30 tablets of gemfibrozil 600mg on 02/14/23, 03/17/23, and 04/14/23. -The pharmacy did not have an order to discontinue gemfibrozil 600mg. -The Primary Care Providers (PCP) would send electronic orders to the pharmacy. Interview with the Administration on 05/09/23 on 4:45pm revealed: -Gemfibrozil was discontinued months ago. -She knew gemfibrozil was still and entry on the MAR. -She would write, "discontinued" by the entry on the MAR. -She did not know the pharmacy had an active order for gemfibrozil 600mg twice daily. -The Primary Care Provider (PCP) had written an order to discontinue gemfibrozil. -She did not recall faxing the discontinued order to the pharmacy. -She thought the PCP sent an electronic order to the pharmacy. -She could not locate a discontinue order for gemfibrozil. -She did not know the pharmacy was continuing dispensing gemfibrozil. Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 05/09/23 at 3:50pm was unsuccessful. Refer to the Administrators interview on 05/09/23 at 4:45pm. 3. Review of Resident #3's current FL-2 dated 03/29/23 revealed: -Diagnosis included arthritis, hypertension, anxiety, anemia, hyperlipidemia, and diabetes mellitus.	C 330		

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-There was an order for meloxicam 7.5mg (used to treat pain and inflammation related to arthritis) twice daily.

Review of Resident #3's March 2023 medication administration record (MAR) revealed:
-There was an entry for meloxicam 7.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation meloxicam was administered daily from 03/01/23 to 03/31/23.

Review of Resident #3's April 2023 MAR revealed:
-There was an entry for meloxicam 7.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation meloxicam 7.5mg was administered daily from 04/01/23 to 04/30/23.

Review of Resident #3's May 2023 MAR from 05/01/23 to 05/09/23 revealed:
-There was an entry for meloxicam 7.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation meloxicam 7.5mg was administered daily from 05/01/23 to 05/09/23.

Observation of Resident #3's medications on hand on 05/09/23 at 1:56pm revealed there was no meloxicam available for administration.

Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/09/23 at 3:11pm revealed:
-The pharmacy received Resident 3's FL-2 dated 3/29/23.
-The pharmacy was informed Resident #3

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C 330	Continued From page 19 brought medications with her from home when admitted to the facility. -The pharmacy profiled meloxicam 7.5mg twice daily but had not filled the prescription. Telephone interview with Resident #3's local pharmacy on 05/09/23 at 4:10pm revealed: -The pharmacy dispensed 60 meloxicam 7.5mg to be administered twice daily on 05/17/22. -The pharmacy filled a prescription for 60 meloxicam 7.5mg on 07/22/23, however Resident #3 failed to pick up the medication. Interview with the Administration on 05/09/23 at 4:45pm revealed: -She administered meloxicam 7.5mg to Resident #3 this morning. -She must have administered the last pill this morning, because she remembered administering the medication. -She knew Resident #3 brought her medications with her to the facility when she was admitted on 03/29/23. -She thought all her medications were available for administration. Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 05/09/23 at 3:50pm was unsuccessful. Refer to the Administrators interview on 05/09/23 at 4:45pm. _____ Interview with the Administrator on 05/09/23 at 4:45pm revealed: -She sent FL-2's to the pharmacy when a new resident was admitted to the home. -She did not compare annual FL-2's with the current medication list to ensure all medications were listed on the FL-2.	C 330		

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C 330	Continued From page 20 -She audited the medication cart every quarter. -She audited the medication cart to ensure that the medications on the MAR were in the medication cart. -She did not realize there were some medications on the medication cart that did not match the MAR. -She did not notice the dispensed date on the blister packs. -She needed to pay more attention to the medications when auditing the medication cart.	C 330		
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:	C 342		

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C 342	Continued From page 21 Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #3) including inaccurate documentation of a blood pressure medication and a medication to for depression (#1); and a topical ointment for pain (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 04/03/23 revealed diagnoses included schizophrenia disorder and diabetes mellitus. a. Review of Resident #1's current FL-2 dated 04/03/23 revealed: -There were no medications listed on the FL-2. -There was a hand-written entry that read "see attached." -The attachment was a list of Resident #1's current medication list. -There was an order for lisinopril 5mg (used to treat elevated blood pressure) daily. Review of Resident #1's May 2023 medication administration record (MAR) from 05/01/23 to 05/09/23 revealed: -There was an entry for lisinopril 5mg daily with an administration time of 8:00am. -There was documentation lisinopril 5mg was administered from 05/01/23 to 05/09/23. Observation of Resident #1's medication on hand on 05/09/23 at 1:10pm revealed: -There was a blister pack with 3 of 30 lisinopril 5mg dispensed on 03/17/23 available for administration. -There was a blister pack with 25 of 30 lisinopril 10mg dispensed on 05/03/23 available for administration.	C 342		

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C 342	Continued From page 22 Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/09/23 at 3:11pm revealed: -The pharmacy had an order for lisinopril 10mg daily dated 05/01/23. -The order for lisinopril 0.5mg was discontinued when lisinopril 10mg was ordered. -The pharmacy would print the MARs and send the MARs to the facility the last week of the month. -The pharmacy would enter the new order, but it would not print on the MAR until the following month since the MARs had been sent to the facility. -The facility was responsible for changing the entry on the MAR since they had been printed and sent to the facility. Interview with the Administrator/Medication Aide (MA) on 05/09/23 at 4:45pm revealed: -She did not know Resident #1 had an order to increase lisinopril to 10mg daily. -She did not receive a copy of the lisinopril order dated 05/01/23. -The pharmacy had printed and shipped the MARs to the facility. -Since she did not have a copy of the lisinopril order, she did not know to make the change on the MAR. -She did not realize the pharmacy dispensed lisinopril 10mg on 05/03/23. b. Review of Resident #1's current FL-2 dated 04/03/23 revealed: -There were no medications listed on the FL-2. -There was a hand-written entry that read "see attached." -The attachment was a list of Resident #1's current medication list.	C 342		

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C 342	Continued From page 23 -There was an order for fluoxetine 20mg (used to treat depression) daily. Review of Resident #1's March 2023 medication administration record (MAR) revealed: -There was an entry for fluoxetine 60mg daily with an administration time of 8:00am. -There was documentation fluoxetine 60mg was administered from 03/01/23 to 03/31/23 Review of Resident #1's April 2023 MAR revealed: -There was an entry for fluoxetine 60mg daily with an administration time of 8:00am. -There was documentation fluoxetine 60mg was administered from 04/01/23 to 04/30/23. Review of Resident #1's May 2023 MAR from 05/01/23 to 05/09/23 revealed: -There was an entry for fluoxetine 60mg daily with an administration time of 8:00am. -There was documentation fluoxetine 60mg was administered from 05/01/23 to 05/09/23. Observation of Resident #1's medication on hand on 05/09/23 at 1:10pm revealed: -There was a blister pack with 1 of 30 fluoxetine 20mg dispensed on 03/17/23 available for administration. -There was a blister pack with 30 of 30 fluoxetine 20mg dispensed on 05/03/23 available for administration. Telephone interview with the pharmacy technician at the facility's contracted pharmacy on 05/09/23 at 3:11pm revealed: -The pharmacy had an order for fluoxetine 20mg daily. -The pharmacy dispensed 30 tablets of fluoxetine 20mg on 02/14/23, 03/17/23 and 05/03/23.	C 342		

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-The pharmacy did not receive an order for fluoxetine 60mg as entered on the MAR.
-The entry for fluoxetine was entered incorrectly.
-The pharmacy had not been notified from the facility regarding the discrepancy in the dosage dispensed and the dosage entered on MAR.

Interview with the Administrator/Medication Aide (MA) on 05/09/23 at 4:45pm revealed:
-She knew Resident #1 had an order for fluoxetine 20mg daily.
-She had not noticed Resident #1's fluoxetine was entered as 60mg on the MAR.
-She had not called the pharmacy to question why 60mg was entered on the MAR and 20mg was being dispensed.

2. Review of Resident #3's current FL-2 dated 03/29/23 revealed:
-Diagnosis included arthritis, hypertension, anxiety, anemia, hyperlipidemia, and diabetes mellitus.
-There was an order for diclofenac sodium 1% (used for pain) four times daily.

Review of Resident #3's May 2023 medication administration record (MAR) from 05/01/23 to 05/08/23 revealed:
-There was a hand-written entry for diclofenac sodium 1% four times daily with a scheduled administration time of 8:00am, 12:00pm, 4:00pm and 8:00pm.
-There was no documentation diclofenac sodium was administered four times a day from 05/01/23 to 05/08/23.

Observation of Resident #3's medication on hand on 05/09/23 at 1:10pm revealed:
-There was a tube of diclofenac sodium 1% available for administration.

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C 342	Continued From page 25 -The tube of diclofenac sodium was opened with ¾ of the medication remaining. Interview with Resident #3 on 05/09/23 at 4:30pm revealed: -She complained of pain in her knees. -The diclofenac sodium cream helped with her pain. -She thought diclofenac sodium cream was applied to her knees two to three times a day. -She did not have any pain in her knees now. Interview with the Administrator/Medication Aide (MA) on 05/09/23 at 4:45am revealed: -Diclofenac sodium was not electronically entered on the MAR from the pharmacy. -She made a hand-written entry of diclofenac sodium when she reviewed the MARs. -She administered diclofenac sodium 1% to Resident #3. -She forgot to sign the MAR after she had administered diclofenac sodium to Resident #3.	C 342		
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, interviews, and record reviews, the facility failed to ensure medications left on top of a medication cart were locked when not under the direct physical supervision of a medication aide observed during the 8:00am	C 353		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HEART FAMILY CARE HOME	131 HUNTINGTON RD LOUISBURG, NC 27549

(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 353	Continued From page 26 facility tour. Review of the facility's resident census report dated 05/09/23 revealed there was a census of 6 residents. Observation of the medication cart on 05/09/23 at 8:05am - 10:30pm revealed: -The locked medication cart was in the living room. -The medication aide (MA) had left the facility. -There were two plastic medication cups on top of the medication cart. -There was a resident's name written on each medication cup. -Both medication cups contained 5 tablets. -At 8:05am, there was a resident sitting in the living room and another resident at the dining room table. -Between 8:22am and 10:15am, residents continued to walk past the medication cart, going to and from their bedroom, the living room, and the kitchen. Interview with the personal care assistant on 05/09/23 at 8:23am and 10:15am revealed: -The Administrator/MA prepared the medications to administer to two residents. -The two residents were in the showers when it was time for the Administrator/MA to administer their medications. -The Administrator left the facility and was going to administer the medications when she returned. -At 10:15am, she threw the medications away because she did not want the residents to get them. -She did not think about throwing them away at 8:23am when it was brought to her attention. Interview with the Administrator/MA on 05/09/23	C 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl035033	A. BUILDING: _____ B. WING _____	R 05/09/2023

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C 353	Continued From page 27 at 4:45pm revealed: -She did not know how medications for two residents were on the top of the medication cart. -She administered the 8:00am medications to all residents before she left the facility. -She did not know where the medications came from. -She had the only key to the medication cart.	C 353		