STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	R 08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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 Secton conducted a follow-up survey on August 3, 2023.	{C 000}		
{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: FOLLOW-UP TO A TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#1) related to medication orders for a blood pressure medication (#1). The findings are: Observation of Resident #1 on 08/03/23 at 8:26am revealed: -The medication aide (MA) called Resident #1 into the kitchen and administered him his morning medications. -The medications were in a medication cup the MA handed him. -He returned to the living room. -At 8:31am the MA called Resident #1 to the	{C 330}		

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{C 330}	Continued From page 1	{C 330}		

medication room and took his blood pressure and recorded the results; his systolic blood pressure (SBP) was 109.

Review of Resident #1's current FL2 dated 12/07/22 revealed diagnoses included schizophrenia, and hypertension.

Review of a physician's order for Resident #1's dated 05/11/23 revealed:
-There was an order for propranolol (used to treat high blood pressure) 10mg once daily.
-Take blood pressure prior to administering and hold dose if SBP was below 100.

Review of Resident #1's medication administration record (MAR) for 08/03/23 at 8:33am revealed:
-There was an entry for a blood pressure check once daily scheduled at 8:00am prior to administering propranolol 10mg; hold the dose of propranolol if the SBP was less than 100.
-There was nothing documented for 08/03/23.
-There was an entry for propranolol 10 mg once daily scheduled at 8:00am; hold for SBP less than 100.
-There was nothing documented for 08/03/23.

Review of Resident #1's blood pressure log for 08/01/23 to 08/03/23 at 8:33am revealed there was an entry on 08/03/23 for SBP of 109.

Observation of Resident #1's medication on hand on 08/03/23 at 1:14pm revealed:
-Resident #1's propranolol was dispensed in a multidose package.
-There were multiple tablets and capsules in each bubble.
-There were separate instructions for each medication in the bubble.

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{C 330}	Continued From page 2	{C 330}		

-Propranolol 10mg was listed and instructions included to hold if SPB was less than 100.

Interviews with Resident #1 on 08/03/23 at 8:31am and 9:09am revealed:
-His blood pressure was checked every day in the morning.
-Sometimes his blood pressure was checked before he was administered his medications and sometimes it was after.
-His blood pressure was checked by the MA after he had his mooring medication today, 08/03/23.
-He felt fine and had not had any problems with his blood pressure.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 08/03/23 at 2:03pm revealed:
-Resident #1 had a current order for propranolol 10mg once daily with parameters to check blood pressure prior to administering; if SBP was less than 100 to hold the dose.
-Propranolol was used to treat blood pressure by lowering it.
-The blood pressure check was necessary prior to administering propranolol so the MA would be aware of the resident's SBP; they would not know whether to hold the dose or administer it without doing the blood pressure check.
-If Resident #1 was administered the propranolol and his SBP was below 100 his blood pressure could become too low and he could pass out.

Telephone interview with Resident #1's primary care provider (PCP) on 08/03/23 at 2:56pm revealed:
-Resident #1 had an order for propranolol to control his high blood pressure.
-Resident #1 had the order hold the propranolol if his SBP was lower than 100 because his blood

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{C 330}	Continued From page 3	{C 330}		

pressure could drop too low if he was administered the medication with a low SBP.
-Resident #1 could become dizzy, he would be at risk for a fall, or he could pass out.
-She expected the facility to follow the order and take the blood pressure prior to administering the propranolol.

Interview with the MA on 08/03/23 at 8:37 am revealed:
-She had popped all of Resident #1's medication into a medication cup and then took the cup to the kitchen to administer it to the resident; including his propranolol because it was included in a multidose package.
-She knew she had to check Resident #1's blood pressure every morning.
-She checked Resident #1's blood pressure after she administered his propranolol and documented it on the blood pressure log.
-She knew she should have done the blood pressure check prior to administering Resident #1 his propranolol but she did not know why.
-She was not aware Resident #1 had parameters for administering his propranolol.
-She followed the medication administration record when she administered medications.
-She usually reviewed the MAR before administering medications, but she was very busy that morning, 08/03/23.
-She should have reviewed the MAR before she administered Resident #1 his propranolol.
-She administered Resident #1 his propranolol before she took checked his SBP; documented the administration of the propranolol after she documented the SBP results.
-She was fortunate Resident #1's blood pressure was within the parameters and did not fall below the systolic parameter of less than 100.

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{C 330}	Continued From page 4 Interview with a second MA on 08/03/23 at 3:29pm revealed: -He read the MAR prior to administering medications. -He checked Resident #1's blood pressure before administering his medications because he knew propranolol had to be held if Resident's #1's SBP was less than 100. -He documented on the MAR when he had to hold Resident #1's propranolol. Telephone interview with the Administrator on 08/03/23 at 4:07pm revealed: -He expected the MA's for follow the MAR when they administered medications. -He expected the parameters for all medications to be followed including the parameters for the SBP for Resident #1's propranolol.	{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	{C 342}		

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{C 342}	Continued From page 5 (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 the medication administration records were completed for 1 of 3 sampled residents (#2,). The findings are: Observation of medication aide (MA) on 08/03/23 at 8:31am revealed: -She administered two residents their medication in the kitchen and then went into the medication room. -There were separate medication administration records (MARs) for each resident. -The MA proceeded to document the medication administrations for each resident. -She did not document the morning medication administration for resident #2 on 08/03/23. Review of Resident #2's current FL2 dated 07/13/23 revealed: -Diagnoses included diabetes mellitus, hypertension, heart disease, left leg amputee, glaucoma, and paranoid schizophrenia. -There was an order for aripiprazole (used to treat schizophrenia) 15mg daily. -There was an order for clopidogrel (used to prevent blood clots) 75mg daily. -There was an order for gabapentin (used to prevent seizures) 100mg twice daily. -There was an order for metoprolol tartrate (used to treat high blood pressure) 50mg twice daily.	{C 342}		

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{C 342}	Continued From page 6 Review of Resident #2's medication administration record (MAR) for 08/03/23 revealed: -There was an entry for aripiprazole 15mg daily scheduled at 7:00am. -There was no documentation aripiprazole was administered on 08/03/23 at 7:00am. -There was an entry for clopidogrel 75mg daily scheduled at 7:00am. -There was no documentation clopidogrel was administered on 08/03/23 at 7:00am. -There was an entry for gabapentin 100mg twice daily scheduled at 7:00am and 7:00pm. -There was no documentation gabapentin was administered on 08/03/23 at 7:00am. -There was an order for metoprolol tartrate 50mg twice daily at 7:00am and 7:00pm. -There was no documentation metoprolol tartrate was administered on 08/03/23 at 7:00am. Observation of Resident #2's medications on hand on 0/03/23 at 1:22pm revealed: -Resident #2's medications were dispensed from the pharmacy in multidose bubble packages and single dose packages. -Each bubble included the medication name, dosage, administration date and time. -Resident #2's aripiprazole, gabapentin and metoprolol tartrate were in the same multidose bubble package. -Resident #2's gabapentin was in a single dose bubble package with the administration date and time. -Resident #2's multidose package dated for 08/03/23 at 7:00am had been punched. -Resident #2's single dose package for gabapentin dated 08/03/23 at 7:00am had been punched. Interview with the MA on 08/03/23 at 8:37 am	{C 342}		

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{C 342}	Continued From page 7 revealed: -She had administered all the residents' their medications that morning but had not had time to sign off on each of the MARs. -She was the only MA administering medication that morning. -She usually signed the MAR immediately after she administered a resident's medication, but she was behind that morning, 08/03/23. -Once she was caught up, she had signed and documented administration of medications on all the residents' MARs at one time. -She followed the MAR when she punched the medication out of the packages. Telephone interview with the Administrator on 08/03/23 at 4:07pm revealed: -The MAs had been trained to document on the MAR after each medication administration. -Each medication and resident were to be documented one at a time. -He expected the MA to check the medication to the MAR, punch the medication out of the package, verify the right resident, administer the medication and then document on the MAR. -Documenting the administration of the medications after all the residents had been administered their medications was unacceptable and he would retrain the staff.	{C 342}		