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(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 a follow-up survey on November 8, 2023.	{C 000}		
{C 201}	10A NCAC 13G .0701 (b) Admission Of Residents 10A NCAC 13G .0701 Admissions Of Residents (b) Exceptions. People are not to be admitted: (1) for treatment of mental illness, or alcohol or drug abuse; (2) for maternity care; (3) for professional nursing care under continuous medical supervision; (4) for lodging, when the personal assistance and supervision offered for the aged and disabled are not needed; or (5) who pose a direct threat to the health or safety of others. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on interviews, and record reviews, the facility failed to ensure 1 of 2 sampled residents (#1) was not admitted for the treatment of a mental illness. The findings are: Review of Resident #1's current FL-2 dated 08/02/23 revealed: -Diagnoses included schizophrenia. -The recommended level of care was domiciliary.	{C 201}		

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{C 201}	Continued From page 1 -The resident was constantly disoriented. -The resident was a wanderer. -There were no other diagnoses listed. -There was an order for Invega extended release (ER) (used to treat schizophrenia) 6mg every morning. -There was an order for trazodone (used to treat depression and anxiety) 100mg at bedtime. -There were no other medications ordered. Review of Resident #1's Resident Register revealed he was admitted to the facility on 07/24/17. Interview with the Administrator on 11/08/23 at 3:37pm revealed: -He knew that Resident #1 needed another diagnosis other than a mental health diagnosis in order to reside at the facility. -Resident #1 also had calluses on the bottom of his feet which he had to have removed at times. -Resident #1 did not receive any medication to treat the calluses on his feet and only received the 2 medications listed on his current FL-2. -Resident #1 had an appointment with his primary care provider (PCP) on 11/07/23 but the resident did not show up for the appointment. -He was going to ask Resident #1's PCP to add a diagnosis regarding the resident's feet at the appointment on 11/07/23 but since the resident did not show up for the appointment, he was unable to get the diagnosis added. Attempted telephone interview with Resident #1's PCP on 11/08/23 at 10:01am was unsuccessful.	{C 201}		
{C 301}	10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services	{C 301}		

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{C 301}	Continued From page 2 10A NCAC 13G .0906 Other Resident Services (f) Visiting. (1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator; (2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home; (3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION Based on these findings, the previous A2 Violation was not abated. Based on interviews and record reviews for 1 of 2 sampled residents, the facility failed to record an	{C 301}		

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{C 301}	Continued From page 3	{C 301}		

expected time of return when a resident left the facility and failed to immediately notify local law enforcement and the county Department of Social Services (DSS) when a resident did not return to the facility and their whereabouts were unknown (#1).

The findings are:

Review of Resident #1's current FL-2 dated 08/02/23 revealed:
-Diagnoses included schizophrenia.
-The resident was constantly disoriented.
-There was an order for Invega extended release (ER) (used to treat schizophrenia) 6mg every morning.
-There was an order for trazodone (used to treat depression and anxiety) 100mg at bedtime.

Review of Resident #1's record revealed he was his own guardian.

Review of the facility's missing client policy, not dated, revealed:
-A curfew will be enforced for any resident who is away from the home.
-In the event the client does not return within the curfew the staff will respond immediately by calling 911, notifying the Administrator or supervisor in charge (SIC), notifying the client's responsible party, and making documentation of the incident and the results of the incident.

Interview with the Administrator on 11/08/23 at 9:13am revealed:
-Resident #1 was on leave from the facility.
-Resident #1 left the facility with his family member on 10/23/23.
-He expected Resident #1's family member to return the resident to the facility sometime last

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{C 301}	Continued From page 4	{C 301}		

week but the resident did not return.
-He spoke to Resident #1 sometime last week, but he did not know what day.
-He thought he last spoke with Resident #1 on 11/02/23 or 11/03/23.
-Resident #1 had an appointment with his primary care provider (PCP) on 11/07/23 for a 6 month follow up and to receive his flu vaccination.
-He had made Resident #1 aware that he had an appointment with his PCP on 11/07/23 when he spoke to him last week.
-Resident #1 told him he would attend his PCP appointment on 11/07/23.
-Resident #1 did not show up for this PCP appointment on 11/07/23.
-Resident #1 was his own guardian.
-Resident #1 was trying to get help with moving to independent living and had gone out with a housing authority earlier in the month to try to find housing.
-He did not think that Resident #1 should move to independent living because he was "into drugs and other things" and he did not think the resident could take care of himself.
-Resident #1 "had it in his head" that he was going to move to independent living so he thought he could leave the facility and come back when he wanted to do so.
-The facility's Owner had spoken with Resident #1's family member on 11/07/23 when the resident did not show up for his PCP appointment.
-He did not know what the family member told the facility's Owner.
-He had just tried to contact Resident #1 by phone but the phone number he had for the resident was out of service.

Review of the facility's resident sign in and out log revealed:

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-The form included a column for the resident's name, the responsible party, time in, time out, and date.
-There was not a column to record a time or date for a resident to return to the facility.
-Resident #1 left the facility at 11:05pm on 10/23/23.
-Resident #1's responsible party was listed as "self".

Review of Resident #1's leave of absence form revealed:
-Proposed date of departure was 10/23/23.
-Proposed date of return was blank.
-Under medication, strength, and dosage trazodone 100mg 1 at bedtime was documented.
-The quantity on leaving for trazodone 100mg was 4.
-Under medication, strength, and dosage Invega ER 6mg 1 every morning was documented.
-The quantity on leaving for Invega ER 6mg was 5.
-The form was signed by Resident #1 on 10/23/23.

Telephone interview with the facility's Owner on 11/08/23 at 9:32am revealed:
-She called Resident #1 and his family member on 11/07/23 when the resident did not show up for his scheduled PCP appointment.
-She was unable to reach Resident #1 or his family member by phone.
-She spoke to Resident #1's friend on 11/07/23 and she said the resident was at his family member's house and the resident said he was returning to the facility because he had a PCP appointment.
-Resident #1 had been speaking with someone to assist him with independent living.
-She did not think Resident #1 was able to live on

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{C 301}	Continued From page 6	{C 301}		

his own but he did not have a guardian so he could make his own decisions.
-Resident #1 had become fixated on getting his own apartment and had not been the same since he started speaking with someone to assist him with independent living.

Telephone interview with Resident #1's friend on 11/08/23 at 9:45am revealed:
-She did not know where Resident #1 was.
-Resident #1 left her house on 11/02/23 and she had not seen him or spoken to him since then.
-She did not have a way to contact Resident #1 because the phone number she had for him was not in service.

Telephone interview with Resident #1's family member on 11/08/23 at 9:48am revealed:
-She had not seen Resident #1 or spoken to him in months.
-Sometimes Resident #1 stayed with another family member but that family member did not have a phone.

Second interview with the Administrator on 11/08/23 at 10:07am revealed:
-He had not notified local law enforcement or the Department of Social Services (DSS) that Resident #1 had not returned to the facility.
-He had not notified them that Resident #1 had not returned to the facility because he spoke with Resident #1 last week and he said he would be at his PCP appointment on 11/07/23.
-He was not concerned when Resident #1 did not show up at his PCP appointment on 11/07/23 but he was upset that the resident did not show up because now he would have to make another appointment for him.
-He was not concerned that Resident #1 had not returned to the facility because he had left the

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facility and not returned before.
-Resident #1 left the facility in February 2023 and did not return to the facility until June 2023.
-Resident #1 returned to the facility in June 2023 when the Administrator's family member went and retrieved the resident from another family member's house.
-He sent his family member to the house to pick up Resident #1 in June 2023 because he felt he had been gone from the facility too long.
-Resident #1 did not resist returning to the facility when the family member went to retrieve him in June 2023.
-Resident #1's mental health provider was made aware that the resident had been out of the facility for several months at his last mental health appointment.
-Resident #1's mental health provider counseled the resident on the need to take his medications as ordered and told him he needed to show he could be responsible before he could live on his own.
-He did not know exactly where Resident #1 was now but assumed he was with a family member because that was usually where he stayed when he was away from the facility.
-He did not send anyone to retrieve Resident #1 when he did not return to the facility this time because the resident told him he would return to the facility when he talked to him last week.

Third interview with the Administrator on 11/08/23 at 2:44pm revealed:
-When Resident #1 left the facility on 10/23/23 he assumed the resident would be gone for a couple of days.
-He gave Resident #1 4 tablets of trazodone and 5 tablets of Invega ER when he left just in case the resident did not return in a couple of days.
-He did not have Resident #1 sign out how long

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{C 301}	Continued From page 8	{C 301}		

he expected to be away from the facility.
-He did not ask Resident #1 exactly how long he would be away from the facility.
-He provided 4 tablets of trazodone and 5 tablets of Invega ER to Resident #1 when he left the facility because he thought the resident would return sooner if he did not have the medication to take.
-He was not concerned that Resident #1 would have run out of trazodone on 10/27/23 or Invega ER on 10/28/23 because the resident had not taken his medications when he was away from the facility before and he was fine.

Telephone interview with Resident #1 on 11/08/23 at 2:57pm revealed:
-He left the facility about 2 weeks ago to stay with a family member.
-When he left the facility, he did not tell anyone at the facility when he planned to return.
-When he left the facility, he was not sure when he would return.
-The facility provided medications for him to take while he was away, but he had run out of them.
-He did not attend his PCP appointment yesterday because it slipped his mind.
-He planned to return to the facility as soon as he could find transportation back to the facility.

Telephone interview with Resident #1's mental health provider on 11/08/23 at 1:06pm revealed:
-He last had a telehealth visit with Resident #1 on 07/07/23.
-He usually saw Resident #1 every 5 to 6 months.
-Resident #1's trazodone was prescribed to help him sleep better and to help with depression.
-Resident #1 probably would not have any issues from not taking trazodone except he might not rest as well.
-Resident #1 was prescribed Invega ER for

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psychosis (a mental disorder characterized by a disconnection from reality).
-He was concerned that Resident #1 had been away from the facility for several days without his Invega ER.
-Resident #1 being without his Invega ER for several days could cause the resident's psychosis to return which could cause him to become agitated and have disorganized thoughts.
-Becoming agitated could cause Resident #1 to have violent episodes.
-Resident #1 not taking Invega ER for several days put him at increased risk of harming himself or harming others.
-Resident #1 going several days without Invega ER could cause the resident to have hallucinations, paranoia, and confusion.
-These side effects could cause Resident #1 to "wander around" and the resident could become homeless.
-These side effects could also cause Resident #1 to not be aware of his surroundings and not look both ways before crossing a street which could be dangerous for the resident.
-Resident #1 had a history of alcohol and drug issues and had seizures before when he was using drugs and alcohol.
-An increase in Resident #1's psychosis could cause him to use drugs and alcohol again.
-He expected the facility to contact local law enforcement when Resident #1 did not return to the facility when he was expected to return because it was important that the facility find the resident to make sure he was safe.
-It was important that Resident #1 be located because something bad could happen to him due to regression that could be brought on by psychosis.
-Resident #1 needed to start back on Invega ER as soon as possible to adequately treat his

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{C 301}	Continued From page 10 psychosis. -He expected the facility to "track down" Resident #1 so he could take his medications again. -He was not aware that Resident #1 had left the facility before and not returned when he was supposed to return. _____ The facility failed to obtain a return date from a resident (#1) when he left the facility and failed to notify local law enforcement and the Department of Social Services (DSS) when the resident did not return to the facility when he was expected to return and the resident was without medication used to treat psychosis (a mental disorder characterized by a disconnection from reality) for 11 days which could cause hallucinations, paranoia, and confusion as well as causing the resident to become agitated and have disorganized thoughts which put the resident at risk of having violent episodes and increased his risk of harming himself or harming others. This failure resulted in a substantial risk for serious physical harm to the resident and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/08/23 for this violation.	{C 301}		
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	C 342		

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C 342	Continued From page 11 medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 1 of 2 residents (#1) including errors with a medication used to treat schizophrenia and a medication used to treat depression and anxiety. The findings are: Review of Resident #1's current FL-2 dated 08/02/23 revealed: -Diagnoses included schizophrenia. -There was an order for Invega extended release (ER) (used to treat schizophrenia) 6mg every morning. -There was an order for trazodone (used to treat depression and anxiety) 100mg at bedtime. Interview with the Administrator on 11/08/23 at 9:13am revealed: -Resident #1 was on leave from the facility. -Resident #1 left the facility with his family member on 10/23/23.	C 342		

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C 342	Continued From page 12 -He expected Resident #1's family member to return the resident to the facility sometime last week but the resident did not return. Review of the facility's resident sign in and out log on 11/08/23 revealed the resident left the facility at 11:05pm on 10/23/23. Review of Resident #1's leave of absence form on 11/08/23 revealed: -Proposed date of departure was 10/23/23. -Proposed date of return was blank. -Under medication, strength, and dosage trazodone 100mg 1 at bedtime was documented. -The quantity on leaving for trazodone 100mg was 4. -Under medication, strength, and dosage Invega ER 6mg was documented. -The quantity on leaving for Invega ER 6mg was 5. Review of Resident #1's October 2023 medication administration record (MAR) revealed: -There was an entry for Invega ER 6mg every morning scheduled for administration at 7:00am. -Invega ER 6mg was documented as administered on 10/01/23 to 10/31/23. -There was an entry for trazodone 100mg daily at bedtime scheduled for administration at 7:00pm. -Trazodone 100mg was documented as administered on 10/01/23 to 10/31/23. Review of Resident #1's November 2023 MAR revealed: -There was an entry for Invega ER 6mg every morning scheduled for administration at 7:00am. -Invega ER 6mg was documented as administered on 11/01/23 to 11/06/23. -There was an entry for Trazodone 100mg daily at bedtime scheduled for administration at	C 342		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUIDING STAR HEALTH CARE TWO	1564 SPRINGBROOK DRIVE ROCKY MOUNT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 342	Continued From page 13 7:00pm. -Trazodone 100mg was documented as administered on 11/01/23 to 11/05/23. Interview with the Administrator on 11/08/23 at 2:44pm revealed: -He documented that Resident #1 was receiving his medications on his MARs because he sent medication with the resident when he left so he assumed the resident was taking his medications. -He did not know there was a code on the back of the MAR that he should use to document on the MAR if a resident was out of the facility.	C 342		
C936	10A NCAC 13G .1010(d) (e) Pharmaceutical Services 10A NCAC 13G .1010 (d) (e) Pharmaceutical Services (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident ' s absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be	C936		

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C936	Continued From page 14 administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the person accompanying the resident upon the medication ' s release from the facility and shall include at least: (A) the name and strength of the medication; (B) the directions for administration as prescribed by the resident's physician; (C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence; (3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and (4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications ' release from and return to the facility. (e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.	C936		

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C936	Continued From page 15	C936		

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to provide a sufficient amount of medication for 1 of 2 sampled residents (#1) who was on leave from the facility.

The findings are:

Review of the facility's medication label policy, not dated, revealed:
-When a resident is leaving the facility medications will be packaged and labeled by the pharmacy or practitioner.
-The facility will document the medication which includes date checked out, name and strength of the medication, count of the amount sent, count of the amount returned, and signature of the responsible person.

Review of Resident #1's current FL-2 dated 08/02/23 revealed:
-Diagnoses included schizophrenia.
-There was an order for Invega extended release (ER) (used to treat schizophrenia) 6mg every morning.
-There was an order for trazodone (used to treat depression and anxiety) 100mg at bedtime.

Review of the facility's resident sign in and out log revealed:
-Resident #1 left the facility at 11:05pm on 10/23/23.
-There was no documentation of a time or date

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C936	Continued From page 16 for the resident to return to the facility. Review of Resident #1's leave of absence form revealed: -Proposed date of departure was 10/23/23. -Proposed date of return was blank. -Under medication, strength, and dosage trazodone 100mg 1 at bedtime was documented. -The quantity on leaving for trazodone 100mg was 4. -Under medication, strength, and dosage Invega ER 6mg 1 every morning was documented. -The quantity on leaving for Invega ER 6mg was 5. -The form was signed by Resident #1 on 10/23/23. Interview with the Administrator on 11/08/23 at 2:44pm revealed: -When Resident #1 left the facility on 10/23/23 he assumed the resident would be gone for a couple of days. -He gave Resident #1 4 tablets of trazodone and 5 tablets of Invega ER when he left just in case the resident did not return in a couple of days. -He did not have Resident #1 sign out how long he expected to be away from the facility. -He did not ask Resident #1 exactly how long he would be away from the facility. -He only provided 4 tablets of trazodone and 5 tablets of Invega ER to Resident #1 when he left the facility because he thought the resident would return sooner if he did not have the medication to take. -He was not concerned that Resident #1 would have run out of trazodone on 10/27/23 or Invega ER on 10/28/23 because the resident had not taken his medications when he was away from the facility before, and he was fine.	C936		

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C936	Continued From page 17 Telephone interview with Resident #1 on 11/08/23 at 2:57pm revealed: -He left the facility about 2 weeks ago to stay with a family member. -When he left the facility, he did not tell anyone at the facility when he planned to return. -When he left the facility, he was not sure when he would return. -The facility did provide medications for him to take while he was away, but he had run out of them. Telephone interview with Resident #1's mental health provider on 11/08/23 at 1:06pm revealed: -Resident #1's trazodone was prescribed to help him sleep better and to help with depression. -Resident #1 probably would not have any issues from not taking trazodone except he might not rest as well. -Resident #1 was prescribed Invega ER for psychosis (a mental disorder characterized by a disconnection from reality). -He was concerned that Resident #1 had been away from the facility for several days without his Invega ER. -Resident #1 being without his Invega ER for several days could cause the resident's psychosis to return which could cause him to become agitated and have disorganized thoughts. -Becoming agitated could cause Resident #1 to have violent episodes. -Resident #1 not taking Invega ER for several days put him at increased risk of harming himself or harming others. -Resident #1 going several days without Invega ER could cause the resident to have hallucinations, paranoia, and confusion. -These side effects could cause Resident #1 to "wander around" and the resident could become homeless.	C936		

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C936	Continued From page 18 -These side effects could also cause Resident #1 to not be aware of his surroundings and not look both ways before crossing a street which could be dangerous for the resident. -Resident #1 had a history of alcohol and drug issues and had seizures before when he was using drugs and alcohol. -An increase in Resident #1's psychosis could cause him to use drugs and alcohol again. -It was important that Resident #1 be located because something bad could happen to him due to regression that could be brought on by psychosis. -Resident #1 needed to start back on Invega ER as soon as possible to adequately treat his psychosis.	C936		