STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 December 4, 2023.	{C 000}		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that the facility's fire drill logs included a description of the fire drill details. The findings are: Observation of the facility on 12/04/23 at 9:15am revealed: -There were two exits at the facility. -There was an exit on the front of the facility off the living room that led to a small porch with steps and a wheelchair ramp that led to the front yard. -There was an exit to the right of the facility near the residents' bedrooms that led to a small covered porch with a wheelchair ramp that led to	C 100		

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	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

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C 100	Continued From page 1 the side yard. Interview with the Administrator on 12/04/23 at 9:09am revealed: -The facility's current census was six residents. -Two of the facility's residents were at "school" at this time but the other 4 were currently at the facility. Review of the facility's fire drill log on 12/04/23 revealed: -There was a column for the date, time, evacuation time, head count, and signature. -There was no area on the log to record details of the fire drill or the staff involved in the fire drill. -A fire drill was conducted at 10:15am on 11/07/23. -The evacuation time on 11/07/23 was 3 minutes and the head count was 6 people. -A fire drill was conducted at 5:00pm on 11/23/23. -The evacuation time on 11/23/23 was 7 minutes and the head count was 10 people. -A fire drill was conducted at 1:00pm on 12/01/23. -The evacuation time on 12/01/23 was 3 minutes and the head count was 6 people. Observation of a fire drill conducted at the facility on 12/04/23 revealed: -There were 2 residents sitting in the living room. -There was 1 resident in his room which was located next to the living room. -There was one resident sitting in the front yard. -A facility staff member sounded the fire alarm at 11:47am. -When the fire alarm was activated none of the residents moved from where they were sitting. -The staff member sounded the fire alarm again a few seconds later. -The residents did not move from where they were sitting.	C 100		

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C 100	Continued From page 2	C 100		

-The staff member sounded the fire alarm again at 11:48am.
-The residents did not move from where they were sitting.
-At 11:48am the Administrator entered the living room and asked the residents what they were supposed to do when they heard the fire alarm go off.
-None of the residents responded to the Administrator.
-The Administrator then told the residents that they knew they were supposed to get up and go outside when the fire alarm sounded.
-One of the residents in the living room evacuated the facility by the front exit at 11:49am.
-The second resident in the living room continued to sit in a chair.
-The Administrator went into the 3rd resident's room at 11:49am and told him the facility was having a fire drill and he needed to go outside.
-The 3rd resident exited the facility by the front exit at 11:50am.
-The second resident continued to sit in a chair in the living room with his eyes closed.
-The Administrator prompted the second resident to leave the facility again at 11:50am.
-The second resident stated, "I'm going to sit right here."
-When the Administrator prompted the second resident to evacuate the facility again, he continued to sit in the chair and stated, "I don't feel like getting out."
-The second resident never exited the facility.
-At 11:51am the other 2 residents who had exited the facility were observed in the same location in the front yard.

Interview with the 3rd resident on 12/04/23 at 12:43pm revealed:
-The facility had done a few fire drills in the past.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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C 100	Continued From page 3	C 100		

-He had no idea when the facility last performed a fire drill.
-When a fire drill was conducted at the facility the Administrator would set off the fire alarm and the residents would go outside.
-The residents would meet anywhere outside during the fire drill as long as it was away from the porch.
-The second resident usually came outside during fire drills, but he had problems walking.

Interview with the resident sitting in the yard on 12/04/23 at 12:47pm revealed:
-When the fire alarm sounded, he was supposed to get up and go outside.
-When the fire alarm sounded all the residents in the facility would go outside and wait a minute before going back into the facility.

Interview with the 1st resident who exited the facility on 12/04/23 at 12:50pm revealed:
-Fire drills were conducted at the facility often.
-After he exited the building, he was supposed to go to the front yard and he was not supposed to be on the front porch.

Second interview with the 3rd resident on 12/04/23 at 2:27pm revealed:
-He usually exited the facility when he heard the fire alarm sound.
-He was in his room when the fire alarm sounded today, and he thought the facility was testing the alarm and that was why he did not exit the facility until prompted by the Administrator.

Interview with the second resident on 12/04/23 at 3:55pm revealed:
-The facility had fire drills regularly, but he was not sure how often.
-He participated in fire drills at the facility before

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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C 100	Continued From page 4 he just did not want to do so today. -When the fire alarm was sounded on 12/04/23 he did not exit the building because he did not feel like going outside but if it was an actual fire he would get out of the house and away from the front porch and go to the front yard. Interview with the Administrator on 12/04/23 at 2:44pm revealed: -Fire drills were performed at the facility twice a month. -The last fire drill at the facility was performed on 12/01/23. -This was the first time the second resident refused to leave the facility during a fire drill. Second interview with the Administrator on 12/04/23 at 3:53pm revealed: -She did not realize that she needed to document a description of the fire drill on the facility's fire drill log. -She usually did not have to prompt residents to exit the facility during a fire drill. -She thought the residents thought she was "messing with the button" on the smoke detector and they did not realize it was a fire drill and that was why she had to prompt them to leave the facility on 12/04/23. Telephone interview with the facility's primary care provider (PCP) on 12/04/23 at 2:15pm revealed she expected all the residents to evacuate the facility without prompting so they would not get burned if there was an actual fire.	C 100		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service	C 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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C 102	Continued From page 5 Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure that the fire alarm was in safe, working order. The findings are: Observation of the smoke detector located in the hallway on 12/04/23 at 10:02am revealed there was a beeping noise coming from the smoke detector every 37 seconds. Interview with the Administrator on 12/04/23 at 11:45am revealed she did not realize that the smoke detector in the hallway was beeping at this time. Interview with the facility's housekeeper on 12/04/23 at 12:47pm revealed the facility's maintenance director came out to the facility on 12/03/23 and changed the battery because the smoke detector was beeping. Second observation of the smoke detector located in the hallway outside 5 of the resident's rooms on 12/04/23 at 12:37pm revealed the alarm was no longer making a beeping noise. Second interview with the Administrator on 12/04/23 at 12:40pm revealed the facility's	C 102		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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C 102	Continued From page 6 maintenance director had just come to the facility and checked the smoke detector and "got it working again". Third observation of the smoke detector located in the hallway on 12/04/23 at 1:58pm revealed there was a beeping noise coming from the smoke detector every 37 seconds. Third interview with the Administrator on 12/04/23 at 3:35pm revealed: -She did not realize the smoke detector in the hallway had started beeping again. -The batteries in all the smoke detectors in the facility were changed with seasons or when the time changed. -New batteries were installed in all the smoke detectors in the facility on the day of the last time change (The last time change was on 11/04/23). -She noticed that the smoke detector in the hallway was beeping on 12/02/23 and she had the facility's maintenance director come out and change the batteries again.	C 102		
{C 257}	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.	{C 257}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

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{C 257}	Continued From page 7	{C 257}		

This Rule is not met as evidenced by:
FOLLOW-UP TO A TYPE B VIOLATION.

The Type B Violation was not abated.

Based on observations, interviews and record review, the facility failed to ensure food was stored, prepared and served under sanitary conditions, in compliance with Rules Governing the Sanitation of Residential Care Facilities, related to observations of live and dead roaches in the facility's kitchen, dining room and food storage areas.

The findings are:

Review of the facility's current Environmental Health report dated 11/16/23, revealed:
-There were a total of 4 demerits with documentation of approved status.
-There were 4 demerits were identified related to vermin control
-Observations and corrective actions documented in the report included :
-"When opening the top cabinet doors in the kitchen roaches were observed in the cabinet."
-"Exterminator is coming out monthly and bug problem is being made a priority."
-Additional comments documented in the report included:
-"New cabinets, floor, and oven in the kitchen."
-"Ensure that the cabinets are kept clean and free from easily accessible food."

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	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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{C 257}	Continued From page 8 Observations of the kitchen and the attached resident dining room on 12/04/23 revealed: -At 9:29am, there was a used trash bag on the floor in the kitchen (located next to the lower cabinets to the left of the stove), the trash bag opening was not tied or secured shut and there was an incontinent brief on the floor underneath the trash bag. -At 9:30am, there were two dead baby roaches in the drawer to the left of the stove, the drawer contained stickers, pens, and a bag of candy in a plastic bag. -At 9:31am, there was a loaf of bread in the upper cabinet to the left of the stove. -The bag for the bread was open and not tied or secured closed. -At 9:32am, there was a roach on its back near the lid to an open gallon of milk and a container of grated cheese topping. -At 9:33am, there was a roach crawling in the sink with dirty dishes. -At 9:34am, there was a dead roach and excrement in a lower cabinet to the right of the stove that contained canned goods. -At 11:15am, there were approximately six dead roaches in a picture frame located on the buffet table in the dining room. -At 11:20am, there was a build up food debris and black matter located on the dining room floor near the legs of the dining table table. -At 11:23am, there was a roach on a chair that was stored on the dining room table. -At 11:40am, there was a roach crawling on the ceiling in the dining room. -At 11:49am, there was a roach crawling on the floor in the dining room. -At 12:37pm there were two dead roaches on the floor in the kitchen. -At 12:52pm, a glue trap was observed on the floor in the dining room near the dining room	{C 257}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 257}	Continued From page 9	{C 257}		

table, there were approximately 16 dead roaches on the glue trap.
-At 1:40pm, there were two roaches crawling on the floor in the kitchen.
-At 1:50pm, there was a roach crawling near two dead roaches on the floor in the dining room.
-At 4:18pm, there was a roach crawling on the wall in the dining room near the entrance to the kitchen.

Interview with the housekeeper on 12/04/23 at 9:32am revealed:
-He worked at the facility 3 to 4 days a week.
-He cleaned the facility, changed the bed linens, swept, mopped, and took out the trash.
-He saw a few roaches in the kitchen at the facility about a month ago.

Interview with a resident on 12/04/23 at 9:17am revealed he still saw roaches at the facility but there were not as many as there used to be.

Interview with a second resident on 12/04/23 at 9:24am revealed he saw a live roach in the bathroom that morning.

Interview with the Administrator on 12/04/23 at 12:39pm revealed:
-The facility had a contract with pest control company for monthly services.
-Pest control was at the facility and provided treatment for roaches in the beginning of November 2023.
-Pest control would be back to the facility in December 2023.
-The facility completed daily cleaning with the use of a hot water steamer on surfaces in the kitchen.

Interview with a technician at the facility's contracted pest control company on 12/04/23 at

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	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 257}	Continued From page 10 1:33pm revealed: -The facility had a contract for general pest control services which were completed every other month. -General pest control services treated for common pests such as roaches, mice and ants. -The facility's most recent pest control service was 11/01/23 and the next visit was scheduled for 01/03/24. -The technician noted German cockroaches were present during his treatment visit on 11/01/23. -The technician provided the facility's staff with recommendations and instructions related to sanitation measures needed including, dirty dishes left in the sink, grease build up on surfaces, foods left out in open containers/packages, food debris, storage of trash items and clean up of dead roaches and insects. -The pest control treatments would not be as effective if the sanitation measures were not kept up as the roaches would prefer the mentioned sources of food supply over the pest control bait treatments. -Dead roaches should be cleaned up and removed regularly as dead roaches served as an additional food source for live roaches. -Roaches were considered a public health hazard because they carry and spread disease such as E. coli bacteria and could increase respiratory health issues. -The pest control provider was available to provide services sooner than 01/03/24 if the facility's owner requested an earlier service date. A second Interview with the Administrator on 12/04/23 at 2:28pm revealed: -The housekeeper cleaned out the kitchen cabinets at the facility every day. -The housekeeper used a steam cleaner on the	{C 257}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 257}	Continued From page 11 cabinets and countertops. -She was not present when the pest control worker last came to the facility and she was not aware the technician left any additional instructions or recommendations. -She put the glue trap out in the dining room about 2 days ago. -She removed glue traps and replaced them with a new one once it had filled up with roaches. A second interview with the housekeeper on 12/04/23 at 2:30pm revealed: -He was present at the facility the last time the pest control technician was there. -The pest control worker told him to clean with bleach and alcohol and to make sure to clean up dead roaches. Interview with the facility's primary care provider (PCP) on 12/04/23 at 2:15pm revealed: -She expected the facility to follow the recommendations of the pest control company to get rid of the roaches. -It was important that the facility get rid of roaches because they could transmit disease to the residents. _____ The facility failed to maintain sanitary conditions in the the kitchen and dining areas which increased the risk of illness, related to exposure to live and dead roaches. Living and dead roaches were observed in areas used to store, prepare and serve food to residents. The facility's failure to control pests was detrimental to the health and safety of the residents and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/04/23 for this violation.	{C 257}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to clarify medication orders for 2 of 2 sampled residents (#2, #3) related to medication orders for depression, allergies and vitamin supplements (#2) and medication orders for a blood pressure medication (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 04/21/23 revealed: -Diagnoses included osteoarthritis and schizophrenia. -There was an order for Trazodone 50mg one tablet at the hour of sleep. -There was no order for Vitamin B1 100mg one capsule daily for vitamin supplement. -There was no order for Vitamin D-3 2,000 unit tablet daily for vitamin supplement. -There was no order for cetirizine (a medication	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 315	Continued From page 13	C 315		

for allergy symptoms) 10mg one tablet daily.

Review of Resident #2's primary care provider (PCP) signed visit noted dated 10/25/23 revealed:
-There was an order for Trazodone 50mg one tablet at the hour of sleep.
-There was no order for Vitamin B1 100mg one capsule daily for vitamin supplement.
-There was no order for Vitamin D-3 2,000 unit tablet daily for vitamin supplement.
-There was no order for cetirizine 10mg one tablet daily.

Review of Resident #2's medication administration record (MAR) dated 11/01/23 through 12/03/23 revealed:
-There was no entry for Trazodone.
-There was an entry for Vitamin B1 100mg one capsule daily for vitamin supplement.
-There was an entry for Vitamin D-3 2,000 unit tablet daily for vitamin supplement.
-There was an entry for cetirizine 10mg one tablet daily.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/04/23 at 10:43am revealed:
-Trazodone had been discontinued by Resident #2's physician on 08/31/21 and was last filled on 04/07/21.
-The most recent orders for Resident #2 were dated 02/06/23 and included orders for Vitamin B1 100mg one capsule daily, Vitamin D-3 2,000 unit, tablet daily and cetirizine 10mg one tablet daily.
-The pharmacy had not received orders to discontinue Vitamin B1, Vitamin D-3 or cetirizine.
-The pharmacy had not received the FL-2 dated 04/21/23.
-If the facility had sent the FL-2 to the pharmacy,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 315	Continued From page 14	C 315		

they would have contacted the PCP for a dispensing prescription or discontinuation orders.

Telephone interview with the facility's contracted pharmacy nurse on 12/04/23 at 1:05pm revealed:
-She was not assigned to complete the reviews of the facility's FL-2s.
-She reviewed the MAR and current pharmacy orders for accuracy.
-She recalled Resident #2's Trazodone had been discontinued quite some time ago.

Interview with the Administrator on 12/04/23 at 2:10pm revealed:
-Resident #2's medications had not changed since February of 2023.
-She was not aware Resident #2's FL-2 and and PCP visit note did not reflect the orders entered on Resident #2's MARs.
-Resident #2's Trazodone was discontinued over one year ago and she was not sure why it was documented on the Fl-2 or PCP visit note.
-The PCP sent all medication orders directly to the pharmacy.
-She had reviewed Resident #2's medication orders with the PCP at the last office visit on 10/25/23 and there were no medication changes, so she did not contact the pharmacy, but she did not review the documentation in the visit note.

Interview with Resident #2 on 12/04/23 at 3:55pm revealed:
-He went to regular appointments with his PCP.
-He had no concerns related to his medication orders or receiving his medications.
-He slept good and had no concerns related to difficulty sleeping.
-He had no other concerns or issues to report.

Attempted telephone interview with Resident #2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 315	Continued From page 15 PCP on 12/04/23 at 2:53pm was unsuccessful. 2. Review of Resident #3's current FL-2 dated 07/17/23 revealed: -Diagnosis included hypertensive disorder. -There was an order for Lisinopril (used to treat high blood pressure) 5mg every evening. Telephone interview with a pharmacy technician at Resident #3's private pharmacy on 12/04/23 at 1:47pm revealed: -Resident #3's Lisinopril 5mg had been discontinued by his private physician on 10/03/23. -Ninety tablets of Lisinopril 5mg was last dispensed for Resident #3 on 07/13/23. Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an entry for Lisinopril 5mg every evening scheduled for administration at 8:00pm. -Lisinopril 5mg was documented as administered at 8:00pm on 11/01/23 to 11/30/23. Observation of Resident #3's medications on hand on 12/04/23 at 11:09am revealed there was a medication card from the facility's contracted pharmacy with a dispense date of 11/20/23 which contained 3 tablets of Lisinopril 5mg. Interview with the facility's nurse on 12/04/23 at 12:54pm revealed: -She reviewed MARs at the facility weekly. -Resident #3 received his medication from a private pharmacy. -She was trying to get Resident #3 switched to the facility's contracted pharmacy, but it had been difficult because the pharmacy said they needed a discharge from his private pharmacy first. -She thought the facility's contracted pharmacy had dispensed a courtesy supply of Lisinopril 5mg	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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C 315	Continued From page 16 for Resident #3 in November 2023. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/04/23 at 11:29am revealed 7 tablets of Lisinopril 5mg was dispensed for Resident #3 on 11/20/23. Interview with the Administrator on 12/04/23 at 3:53pm pm revealed: -Resident #3 received his medications from a private pharmacy. -When Resident #3 received his medications from the private pharmacy in October 2023 he did not receive Lisinopril 5mg. -She called Resident #3's private pharmacy when he did not receive Lisinopril in October 2023 and they transferred her to a nurse. -The nurse told her that Resident #3's Lisinopril 5mg had been discontinued on 10/03/23. -She did not know what date she spoke with the nurse. -She requested a discontinue order from the nurse, but she never received it. -Resident #3 had medications when he was admitted to the facility, and she did not discard those medications. -She had been using Resident #3's extra Lisinopril 5mg that he had when he was admitted to the facility and that was how she was able to administer Lisinopril 5mg to him in November 2023. -The facility's contracted pharmacy sent 7 tablets of Lisinopril 5mg for Resident #3. -There were 3 tablets of Lisinopril 5mg left in Resident #3's medication card because she was saving it in case the resident needed it later. -She continued to administer Resident #3's Lisinopril 5mg because she never received the discontinue order from his private physician.	C 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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{C 330}	Continued From page 17	{C 330}		
{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: Based on observations, interviews, and record reviews the facility failed to administer medications as ordered to 1 of 3 resident's sampled (#3) including a medication used to treat high blood pressure. The findings are: Review of Resident #3's current FL-2 dated 07/17/23 revealed diagnoses included hypertensive disorder and diabetes. a. Review of Resident #3's current FL-2 dated 07/17/23 revealed there was an order for Lisinopril (used to treat high blood pressure) 5mg every evening. Telephone interview with a pharmacy technician at Resident #3's private pharmacy on 12/04/23 at 1:47pm revealed: -Resident #3's Lisinopril 5mg had been discontinued by his private physician on 10/03/23. -Ninety tablets of Lisinopril 5mg was last dispensed for Resident #3 on 07/13/23.	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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{C 330}	Continued From page 18 Review of Resident #3's November 2023 medication administration record (MAR) revealed: -There was an entry for Lisinopril 5mg every evening scheduled for administration at 8:00pm. -Lisinopril 5mg was documented as administered at 8:00pm on 11/01/23 to 11/30/23. Observation of Resident #3's medications on hand on 12/04/23 at 11:09am revealed there was a medication card from the facility's contracted pharmacy with a dispense date of 11/20/23 which contained 3 tablets of Lisinopril 5mg. Interview with the facility's nurse on 12/04/23 at 12:54pm revealed: -She reviewed MARs at the facility weekly. -She compared the resident's medications to what was on the MAR for the resident. -Resident #3 received his medication from a private pharmacy. -She was trying to get Resident #3 switched to the facility's contracted pharmacy, but it had been difficult because the pharmacy said they needed a discharge from his private pharmacy first. -She thought the facility's contracted pharmacy had dispensed a courtesy supply of Lisinopril 5mg for Resident #3 in November 2023. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/04/23 at 11:29am revealed 7 tablets of Lisinopril 5mg was dispensed for Resident #3 on 11/20/23. Interview with the Administrator on 12/04/23 at 3:53pm pm revealed: -Resident #3 received his medications from a private pharmacy. -When Resident #3 received his medications from the private pharmacy in October 2023 he did not receive Lisinopril 5mg.	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 330}	Continued From page 19 -She called Resident #3's private pharmacy when he did not receive Lisinopril in October 2023 and they transferred her to a nurse. -The nurse told her that Resident #3's Lisinopril 5mg had been discontinued on 10/03/23. -She did not know what date she spoke with the nurse. -She requested a discontinue order from the nurse, but she never received it. -Resident #3 had medications when he was admitted to the facility, and she did not discard those medications. -She had been using Resident #3's extra Lisinopril 5mg that he had when he was admitted to the facility and that was how she was able to administer Lisinopril 5mg to him in November 2023. -The facility's contracted pharmacy sent 7 tablets of Lisinopril 5mg for Resident #3. -There were 3 tablets of Lisinopril 5mg left in Resident #3's medication card because she was saving it in case the resident needed it later. -She continued to administer Resident #3's Lisinopril 5mg in November 2023 because she never received the discontinue order from his private physician. b. Review of Resident #3's physician visit note dated 11/17/23 revealed: -The visit note was signed by Resident #3's primary care provider (PCP). -There was a notation which read Lisinopril 2.5mg every day for 30 days. -The prescribed date for the Lisinopril 2.5mg was 11/17/23. -Resident #3's blood pressure (BP) was 115/71. Review of Resident #3's November 2023 MAR revealed there was no entry for Lisinopril 2.5mg.	{C 330}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 330}	Continued From page 20 Review of Resident #3's December 2023 MAR revealed: -There was an entry for Lisinopril 2.5mg every day scheduled for administration at 8:00am. -Lisinopril 2.5mg was documented as administered at 8:00am on 12/01/23 to 12/04/23. Observation of Resident #3's medications on hand on 12/04/23 at 11:09am revealed there was no Lisinopril 2.5mg. Interview with Resident #3 on 12/04/23 at 9:17am revealed: -His PCP changed his BP medication about 2 weeks ago. -He was on Lisinopril 5mg, but he thought the PCP changed it to another BP medication. -He was only given enough of the new BP medication to last for about a week and then he ran out of it. Interview with the Administrator on 12/04/23 at 11:16am revealed Resident #3 usually received his medications from a private pharmacy. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/04/23 at 11:29am revealed: -The facility's contracted pharmacy did not provide medications to Resident #3 because he received his medications from a private pharmacy. -She saw that 30 tablets of Lisinopril 2.5mg were dispensed for Resident #3 on 11/22/23. -The 30 tablets of Lisinopril 2.5mg for Resident #3 were never sent to the facility. -The Lisinopril 2.5mg for Resident #3 was probably not sent to the facility because there was a note that the resident's medications were provided by a private pharmacy.	{C 330}		

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	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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{C 330}	Continued From page 21 Second interview with the Administrator on 12/04/23 at 3:53pm revealed: -When Resident #3 saw his PCP on 11/17/23 she said she was writing a prescription for Lisinopril 2.5mg for Resident #3. -She never received Resident #3's Lisinopril 2.5mg from the pharmacy. -She spoke to someone at the facility's contracted pharmacy sometime in November 2023 and she was told they would send out Resident #3's Lisinopril 2.5mg. -She "left it up to the girl at the pharmacy" to send Resident #3's Lisinopril 2.5mg and had not contacted the pharmacy again. Telephone interview with Resident #3's PCP on 12/04/23 at 2:15pm revealed: -She saw Resident #3 once and that was on 11/17/23. -At the visit on 11/17/23 she was told that Resident #3 was no longer taking Lisinopril 5mg. -She ordered Lisinopril 2.5mg for Resident #3 on 11/17/23 because he had diabetes, and he needed the medication to help prevent him from developing kidney disease. -Resident #3 was on another BP medication and that was controlling his BP, but he needed to take the Lisinopril 2.5mg to prevent complications with his kidneys in the future.	{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;	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

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{C 342}	Continued From page 22 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration record (MAR) was accurate for 1 of 3 sampled residents (#3) including a medication used to treat high blood pressure. The findings are: Review of Resident #3's current FL-2 dated 07/17/23 revealed diagnosis included hypertensive disorder. Review of Resident #3's physician visit note dated 11/17/23 revealed: -The visit note was signed by Resident #3's primary care provider (PCP). -There was a notation which read Lisinopril 2.5mg every day for 30 days. Review of Resident #3's November 2023 MAR	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 23 revealed there was no entry for Lisinopril 2.5mg. Review of Resident #3's December 2023 MAR revealed: -There was an entry for Lisinopril 2.5mg every day scheduled for administration at 8:00am. -Lisinopril 2.5mg was documented as administered at 8:00am on 12/01/23 to 12/04/23. Observation of Resident #3's medications on hand on 12/04/23 at 11:09am revealed there was no Lisinopril 2.5mg. Interview with the Administrator on 12/04/23 at 11:16am revealed Resident #3 usually received his medications from a private pharmacy. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 12/04/23 at 11:29am revealed: -The facility's contracted pharmacy did not provide medications to Resident #3 because he received his medications from a private pharmacy. -She saw that 30 tablets of Lisinopril 2.5mg were dispensed for Resident #3 on 11/22/23. -The 30 tablets of Lisinopril 2.5mg for Resident #3 were never sent to the facility. -The Lisinopril 2.5mg for Resident #3 was probably not sent to the facility because there was a note that the resident's medications were provided by a private pharmacy. Second interview with the Administrator on 12/04/23 at 3:53pm revealed: -When Resident #3 saw his PCP on 11/17/23 she said she was writing a prescription for Lisinopril 2.5mg for Resident #3. -She never received Resident #3's Lisinopril 2.5mg from the pharmacy.	{C 342}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL046013	A. BUILDING: _____ B. WING _____	R 12/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEAVER'S PINEVIEW HOME	142 WEST LEWISTOWN ROAD MURFREESBORO, NC 27855

(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 24 -She mistakenly marked on Resident #3's December 2023 MAR that Lisinopril 2.5mg had been administered.	{C 342}		