	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	· ,	SURVEY PLETED
		FCL017018	B. WING		08	/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO I, NC 27212	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
	_	sure Section conducted an survey on August 18, 2023				
C 022	10A NCAC 13G .0302 Construction	2 (b) Design And	C 022			
	10A NCAC 13G .0302	2 Design And Construction				
		be planned, constructed, ined to provide the services				
	This Rule is not met TYPE B VIOLATION	·				
	reviews, the facility fa evacuation capabilitie the evacuation capab current license for 1 c	ns, interviews, and record iled to ensure the residents' as were in accordance with ility listed on the facility's of 5 sampled residents (#5) of dementia and did not II.				
	The findings are:					
		s license effective 01/01/23 ras licensed for a capacity of ts.				
	Review of the facility's revealed that 5 reside	s census on 08/18/23 ents resided at the facility.				
	Review of the facility's	s fire drill rehearsal record				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
TAVI OD E	AMILY CARE HOME #2	1136 BERT	HA WILSON R	ROAD		
IAILORI	AWILT CARE HOWE #2	BLANCH, I	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 022	Continued From page	e 1	C 022			
	dated 01/05/23 at 9:0	Opm revealed:				
	-The fire drill was con					
	Supervisor-in-Charge					
		rough the front door and				
	went to the tree in the	•				
		ted without difficulty at				
	9:25pm.					
		s fire drill rehearsal record				
	dated 03/03/23 at 10:					
		ducted by the SIC/Owner.				
	went to the tree in the	rough the front door and				
		ted without difficulty at				
	10:45am.	tod William dillouity at				
	Review of the facility's	s fire drill rehearsal record				
	dated 06/01/23 at 4:0					
		ducted by the SIC/Owner.				
		rough the front door and				
	went to the tree in the					
	·	ted without difficulty at				
	4:25pm.					
	Review of Resident #	5's current FL-2 dated				
	11/07/22 revealed dia	ignoses included dementia				
	without behavioral dis	sturbance, hypertension, and				
	hyperlipidemia.					
	Review of Resident #	5's Resident Register				
	revealed an admissio	-				
	TOVCAICU ATT AUTTISSIU	11 date of 00/01/20.				
	Review of Resident #	5's Care Plan dated				
	11/07/22 revealed:					
	-Resident #5 was son	netimes disoriented.				
	-Resident #5 had sigr	nificant memory loss and				
	must be directed.					
	Observation of a fire	drill on 08/18/23 between				

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9:00am-9:06am revealed:

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STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
		FCL017018	B. WING		08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STA	TE, ZIP CODE		
TAVLODE	AMILY CARE HOME #2	1136 BER	THA WILSON R	COAD		
IATLOR	AWILT CARE HOWE #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 022	Continued From page	2	C 022			
	-The SIC/Owner set of the facilityThe alarm was loud a facilityResident #5 did not e-Resident #5 was amitoward her roomResident #5 entered drill. Interview with Reside revealed: -She stayed where sh startedShe did not know wh startedShe did not remember observation of the face revealed the fire alarm Resident #5 did not envealed the fire alarm Resident #5 was sitting room and did not move guardian on 08/21/23 -Resident #5 had a did-People with demential meaning some days follow directions and deresident #5 would not resident #5	and audible throughout the exit the facility. bulating in the hallway her bedroom during the fire ent #5 on 08/18/23 at 9:02am he was when the noise er practicing fire drills. Cility on 08/18/23 at 9:57am in randomly alarmed and exit the facility. Cility on 08/18/23 at 10:06am in randomly alarmed; and in a chair in the living we from the chair.				
	-Resident #5 would no sure she knew what we exit the facility.	eed to be prompted to make				

Division of Health Service Regulation

-All of the residents at the facility were

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	-	
TAYLOR FAMILY CARE HOME #2 1136 BERTHA WILSON ROAD						
	OUR MAN DV OT		NC 27212	PP0//PPD0 P/ AV 05 00PP507/0		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 022	Continued From page	e 3	C 022			
C 022	ambulatory. If a resident was not accept the resident at She thought ambulat walked without a walkeno one had told her resident would be corresident #5 was the diagnosis of dementianesident #5 could be minutes later the resident #6 was not aware to the same and th	ambulatory, she would not at the facility. The facility story meant the resident ster. about any other reason a insidered non-ambulatory, only resident with a sate told something and two dent would not remember. With the Administrator on evealed: The resident did not exit the still. Indiany fire drills at the facility, rebal prompting could not be rills. Interview with Resident #5's for (PCP) on 08//21/23 at the essful. Insure the building was fined in accordance with the city to allow a resident who had cognitive deficits facility independently in y such as a fire. This failure is health, safety, and	C 022			
	B Violation. The facility failed to protection in accordance.	dent and constitutes a Type rovide an acceptable plan of nee with G.S. 131D-34 on				
	08/18/23. A SUMMARY SUSPE	ENSION OF LICENSE WAS				

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ISSUED ON AUGUST 23, 2023.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		(X3) DATE SURVEY COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF PR	ROVIDER OR SUPPLIER		RESS, CITY, STA		
TAYLOR F	AMILY CARE HOME #2	1136 BERT BLANCH, I	THA WILSON R NC 27212	OAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
	10A NCAC 13G .0312 Exits 10A NCAC 13G .0312 Exits (g) In homes with at I determined by a phys to be disoriented or a for resident use shall sounding device that opened. The sound set that it can be heard by of remote sounding decontrol panel for the set the bedroom of the perior in a location accessiby the administrator to the set on observation reviews, the facility fadoors accessible to reaway from the facility was sometimes disorial arms that were of set be heard by staff whee to for the safety of the The findings are: Observation of the enfacility on 08/18/23 at 8:05am-6:00pm reveals	2 Outside Entrance And 2 Outside Entrance and 2 Outside Entrance and 2 Outside Entrance and 2 east one resident who is 3 ician or is otherwise known 3 wanderer, each exit door 3 be equipped with a 3 is activated when the door is 3 shall be of sufficient volume 4 y staff. If a central system 5 evices is provided, the 6 evices is	C 069		

Division of Health Service Regulation

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO , NC 27212	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	facility on 08/18/23 at was located on the be	ond entrance/exit door to the 2:43pm revealed the door edroom hallway and no the door was opened and				
	Interview with a resid revealed: -If he could not sleep night and there were -No one came to che outside during the nig	ent on 08/18/23 at 2:37pm , he went outside during the no alarms on the doors. ck on him when he went that. and resident on 08/18/23 at the nad never heard an alarm on				
	Interview with a third 2:36pm revealed: -He had used the fror outsideHe had never heard door was opened.	resident on 08/18/23 at Int and back door to go an alarm sound when either It #1's current FL-2 dated				
	11/29/22 revealed dia mellitus type 2, schize hypertension, and vita Review of Resident #	agnoses included diabetes ophrenia, hypothyroidism, amin D deficiency. 1's Resident Register				
		:1's Care Plan dated				

Division of Health Service Regulation

-The Supervisor in Charge (SIC) /Owner reported

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
FCL017018 B. WING	08/21/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1136 BERTHA WILSON ROAD BLANCH, NC 27212	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
C 069 Resident #1 had been more irritable the past week related to paranoid delusionResident #1 demonstrated paranoid thoughts. Review of Resident #1's MH Provider's visit note dated 05/02/23 revealed: -Resident #1 reported "the people upstairs stole her food card"Resident #1 demonstrated paranoid thoughts. Review of Resident #1's MH Provider's visit note dated 06/19/23 revealed Resident #1 reported hearing voices coming from rooms in the facility. Review of Resident #1's MH Provider's visit note dated 08/03/23 revealed Resident #1 reported ongoing hallucinations and depression. Interview with Resident #1 on 08/21/23 at 2:15pm revealed: -She used the door in the living room and the door in the hallway to exit the buildingShe did not hear an alarm when she exited the facility doors. Interview with a resident on 08/18/23 at 4:28pm revealed sometimes at night he and Resident #1 would go outside. Telephone interview with a nurse at Resident #1's Primary Care Provider's (PCP) office on 08/21/23 at 12:22pm revealed the facility was expected to have an alarm system on the exit doors to alert the facility staff when Resident #1 went outside, especially with a history of wandering from the facility. Interviews with the SIC/Owner on 08/18/23 at 12:52pm, 2:16pm, 2:43pm, and 3:39pm	

Division of Health Service Regulation

revealed:

STATE FORM 6899 E4Y611 If continuation sheet 7 of 141

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, ZIP CODE TAYLOR FAMILY CARE HOME #2 1138 BERTHA MILSON ROAD BLANCH, NC 27212 PROVIDERS PLAN OF CORRECTION PREFIX (CACH DEFICIENCY MUST DEPICIENCIES) PREFIX (CACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) C 069 Continued From page 7 Resident #1 needed the most supervision because the resident liked to walk. When she returned from running an errand today, 08/18/23, the SIC/Owner's family member told her Resident #1 had walked away from the facility. Resident #1 mod not walk to the mailbox and maybe a ½ mile to a mile down the road. She called the law enforcement agency today, 08/18/23, around 1:00pm because Resident #1 had been gone for cold a hours. Telephone interview with the Administrator on 08/18/23 at 5:00pm revealed: -The SIC/Owner would provide 24/7 monitoring for the residents until an alarm system could be put in place. -Someone would stay in the residents' living quarters, awake, to ensure the residents' safety. Based on observations of the facility on 08/18/23 between 11:00am and 8:00pm Resident #1 wandered from the facility on 08/18/23 between 11:00am and was gone for more than 8 hours, and on 08/21/23 between 9:30am and 2:30pm, Resident #1 life the facility 3 times, with her whereabous unknown to the staff. Refer to the interview with the Selminator on 08/18/23 at 4:43pm. 2. Review of Resident #5's current FL-2 dated		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	1 ' '	(X3) DATE SURVEY COMPLETED	
TAYLOR FAMILY CARE HOME #2 IND IND			FCL017018	B. WING		08/2	1/2023	
C 069 Continued From page 7 -Resident #1 needed the most supervision because the resident liked to walk. -When she returned from running an errand today, 08/18/23, the Side of the Hallow and the facility. -Resident #1 had walked away from the facility. -Resident #1 had to walked away from the facility on 08/18/23 at 5:00pm revealed: -The SiC/Owner would provide 24/7 monitoring for the residents with the Administrator on 08/18/23 between 11:00am and 8:00pm Resident #1 wandered from the facility on 08/18/23 between 11:00am and 8:00pm Resident #1 wandered from the facility and was gone for more than 8 hours, and on 08/21/23 between 9:30am and 2:30pm, Resident #1 had bears on 08/18/23 at 3:00pm. Refer to the telephone interview with the SiC/Owner on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/18/23 at 3:00pm.			1136 BERT	THA WILSON R				
-Resident #1 needed the most supervision because the resident filted to walk. -When she returned from running an errand today, 08/18/23, the SIC/Owner's family member told her Resident #1 had walked away from the facility. -She did not know how long Resident #1 had been gone from the facility. -Resident #1 had not walked away from the facility before and been gone this long. -Resident #1 the mailbox and maybe a ½ mile to a mile down the road. -She called the law enforcement agency today, 08/18/23, around 1:00pm because Resident #1 had been gone for 2 to 3 hours. Telephone interview with the Administrator on 08/18/23 at 5:00pm revealed: -The SIC/Owner would provide 24/7 monitoring for the residents until an alarm system could be put in place. -Someone would stay in the residents' living quarters, awake, to ensure the residents' safety. Based on observations of the facility on 08/18/23 between 11:00am and 8:00pm Resident #1 had wandered from the facility and was gone for more than 8 hours, and on 08/21/23 between 9:30am and 2:30pm, Resident #1 left facility it mes, with her whereabouts unknown to the staff. Refer to the interview with the SIC/Owner on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE	
11/07/22 revealed diagnoses included dementia	C 069	-Resident #1 needed because the resident -When she returned f today, 08/18/23, the Stold her Resident #1 IfacilityShe did not know how been gone from the faresident #1 had not facility before and been gone for and been gone for a facility before and been gone for 2 to 108/18/23, around 1:00 had been gone for 2 to 108/18/23 at 5:00pm resident with put in placeSomeone would stay quarters, awake, to end a gone for 2 to 108/18/23 at 3:00pm, Resident with her whereabouts Refer to the interview 08/18/23 at 3:00pm. Refer to the telephone Administrator on 08/22. Review of Resident	the most supervision liked to walk. From running an errand SIC/Owner's family member had walked away from the wolong Resident #1 had acility. walked away from the en gone this long. valk to the mailbox and mile down the road. Inforcement agency today, Opm because Resident #1 to 3 hours. with the Administrator on evealed: Id provide 24/7 monitoring an alarm system could be v in the residents' living insure the residents' safety. Ins of the facility on 08/18/23 in the facility and was gone for more 08/21/23 between 9:30 am in the staff. In with the SIC/Owner on The interview with the entry at 4:43 pm. In the the facility with the size of the facility with the size of the facility and was gone for more one interview with the size of the facility and was gone for more of the facility at the	C 069				

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without behavioral disturbance, hypertension, and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL017018	B. WING		30	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO	AD		
	T	BLANCI	H, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 069	Continued From pag	e 8	C 069			
	hyperlipidemia.					
	Review of Resident # revealed an admission	#5's Resident Register on date of 08/07/20.				
	Review of Resident # 11/07/22 revealed:					
	-Resident #5 was so -Resident #5 had sig must be directed.	metimes disoriented. nificant memory loss and				
	revealed:	ent #5 on 08/18/23 at 2:26pm				
	living room.	d an alarm on the door in the				
		n the living room to exit the know there was another door				
	guardian on 08/21/23	with Resident #5's legal 3 at 8:45am revealed: liagnosis of dementia.				
	-People with dement meaning some days follow directions and	ia had "up and down days" Resident #5 may be able to other days the resident				
	of alert system to kno and out of the facility	ne facility to have some type by when Resident #5 went in to ensure the resident was				
	safe.					
	Care Provider's (PCF 12:33pm revealed:	with Resident #5's Primary P) nurse on 08/21/23 at liagnosis of dementia.				
	-Resident #5 would r of her dementia and	equire supervision because for her overall safety to				
		as necessary to have some e to monitor Resident #5 for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TAVI OD E	AMILY CARE HOME #2	1136 BER	THA WILSON R	OAD		
IAILORI	AWIET CARE HOWL #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 069	Continued From page	9	C 069			
	her safety.					
	ner salety.					
	Interview with the SIC	C/Owner on 08/18/23 at				
	3:00pm revealed:					
		sident #5 would wander off.				
		rent outside, she came right thought the resident realized				
	she did not want to ge					
-Even when they went on outings, Resident #5 stayed right with her.						
	Attempted telephone	interview with Resident #5's				
	MH provider on 08/21					
	unsuccessful.					
	Refer to the interview 08/18/23 at 3:00pm.	with the SIC/Owner on				
	Refer to the telephone	e interview with the				
	Administrator on 08/2					
	Interview with the SIC 3:00pm revealed:	C/Owner on 08/18/23 at				
	-The alarm system or	the exit doors of the				
	resident's living quart					
	-	stem off about two years				
	ago because of the co					
	being robbed, not for	em was for her safety for the resident's safety				
		on the doors accessible by				
	the residents, it would					
		ng device in addition to the				
		ed on the doors to know				
	when the door was or					
	residents broke it off.					
		when the sounding device or, but it was recently.				
		the resident broke off could				
		sidence if she was in her				

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bedroom and she would not know if the residents

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2	1136 BE	RTHA WILSON RO	AD		
		BLANCI	I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 069	nightShe made rounds in to make sure all the oresidents were in the -The residents knew be locked after 10:00 -None of the resident night." Telephone interview 08/21/23 at 4:43pm r-She thought the facishe did not know the offShe heard "beeps" v-The exit alarms must in the facilityShe had left a voice company that provide another facility in which Administrator. Refer to Tag 243, 10. Personal Care and S Violation).	the facility around 12:00am doors were locked and the ir rooms. the doors were supposed to opm. Its "really went outside late at with the Administrator on evealed: lity had door alarms. It is a larms had been turned when she was at the facility. It go back on the exit doors mail for the security system and security and video for ich she was the	C 069			
	the exit doors to the sounding device whe resident (#1) eloping times in four days; ar was intermittently dis the door and possibly detrimental to the hear	ility to ensure the alarms on facility had an audible en activated resulted in a from the facility at least four and another resident (#5), who coriented, having access to y eloping. This failure was alth, safety, and well-being of institutes a Type B Violation.				
		provide an acceptable plan of nce with G.S. 131D-34 on				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF D	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE ZID CODE	1 06/21/2023	
			HA WILSON R			
TAYLOR F	AMILY CARE HOME #2	BLANCH, N				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 069	Continued From page	e 11	C 069			
	08/18/23.					
	A SUMMARY SUSPE	ENSION OF LICENSE WAS T 23, 2023.				
C 100	10A NCAC 13G .0316 Disaster Plan	6 (e) Fire Safety And	C 100			
	10A NCAC 13G .0316 Plan	6 Fire Safety And Disaster				
	fire evacuation plan e rehearsals shall be m furnished to the count services annually. Th date and time of the r	least four rehearsals of the ach year. Records of aintained and copies ty department of social ne records shall include the ehearsals, staff members description of what the				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
		ews and interviews, the e that fire evacuation plans ast four times yearly.				
	The findings are:					
	Review of the facility's revealed that 5 reside	s census on 08/18/23 ents resided at the facility.				
	dated 01/05/23 at 9:0	ducted by the Supervisor-in				

Division of Health Service Regulation

STATE FORM 6899 E4Y611 If continuation sheet 12 of 141

			E SURVEY PLETED			
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	-	
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 100	went to the tree in the -Drill completed without Review of the facility' dated 03/03/23 at 10: -The fire drill was coreTwo residents left the went to the tree in the -Drill completed without Review of the facility' dated 06/01/23 at 4:00The fire drill was coreTwo residents left the went to the tree in the -Drill completed without to the facilityThe sIC/Owner set of the facilityThe alarm was loud facilityNo residents exited the facilityNo residents exited the facility are sidents exited the facility of the facilityIn Review of Residen 11/29/22 revealed diamellitus type 2, schize hypertension, and vital Observation of Residen 9:02am and 9:06am in the residents are sidents.	rough the front door and a front yard. Out difficulty at 9:25pm. Is fire drill rehearsal record and revealed: Inducted by the SIC/Owner. Induced by the SIC/Owne	C 100			
	-Resident #1 was sitt	ing on her bed in her				

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-Resident #1 continued to stay in her room and

STATE FORM 6899 E4Y611 If continuation sheet 13 of 141

DIVISION	n rieaitii Service Negu		1			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		FCL017018	B. WING		00/	21/2023
		FCE017018			00/2	. 1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAVLODE	AMILY CARE HOME #2	1136 BER	THA WILSON R	ROAD		
IATLOR	FAMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
			1	DEFICIENCY)		
C 100	Continued From page	e 13	C 100			
	. •					
	did not exit when the	fire alarm sounded.				
	Interview with Decide	nt #1 on 08/18/23 at 9:02am				
	revealed:	nt #1 011 06/16/23 at 9.02am				
		at was going on when the				
	noise sounded.	at was going on when the				
	-She wanted the nois	e to ston				
	-She did not know this	•				
	-The facility did not ha					
	-Trie facility did flot fie	ave life drills ofter.				
	Refer to the interview	with the SIC/Owner on				
	08/18/23 at 3:00pm.	with the electronic en				
	00/10/20 dt 0.00pm.					
	Refer to the telephon	e interview with the				
	Administrator on 08/2					
		·				
	2. Review of Residen	t #2's current FL-2 dated				
	05/19/23 revealed dia	ignoses included				
	schizoaffective bipola	r type, schizoaffective				
	personality disorder,	and anxiety disorder.				
	Observation of Resid					
	9:02am-9:06am revea					
		ng in a chair in his room				
		as sounded in the hallway				
	outside of his door.					
		move but continued to sit in				
	his chair in his room.					
	Intonious with Decide	nt #2 on 08/18/23 at 9:03am				
		III #∠ UII U0/ 10/23 at 9:U3am				
	revealed: -He knew the alarm w	voo a fire alarm				
		alarm, he was supposed to				
		it was hot, lay down on the				
	floor, and look for the					[
		cility because he thought it				
	was "role play."	as also loove the facility				
		ne else leave the facility.				
		facility having a fire drill				
	since he moved in, "a	couple of months ago."				

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		1136 BER	THA WILSON R	OAD	
TAYLOR F	FAMILY CARE HOME #2		NC 27212		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 100	Continued From page	e 14	C 100		
	Refer to the interview with the SIC/Owner on 08/18/23 at 3:00pm. Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm. 3. Review of Resident #3's current FL-2 dated 06/07/23 revealed diagnoses included bipolar disorder, schizophrenia, and post-traumatic syndrome disorder.				
	Observation of Resident #3 on 08/18/23 at 9:05am revealed the resident was asleep on his bed; the resident did not exit the room while the fire alarm was alarming.				
	Interview with Resident #3 on 08/18/23 at 11:39am revealed: -He did not hear the fire alarmSomeone was recently at the facility checking the fire alarms; he thought it may have been last week (week of 08/07/23)There had not been any fire drills since he moved into the facility in June 2023The SIC/Owner had never talked to him about fire drills.				
	Refer to the interview 08/18/23 at 3:00pm.	with the SIC/Owner on			
	Refer to the telephone Administrator on 08/2				
	10/27/22 revealed dia health disorder, atten	t #4's current FL-2 dated agnoses included mental tion-deficit/hyperactivity I intellectual developmental			

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STATE FORM 6899 E4Y611 If continuation sheet 15 of 141

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	
			THA WILSON R		
TAYLOR F	AMILY CARE HOME #2	BLANCH,	NC 27212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 100	Continued From page	: 15	C 100		
	Observation of Reside 9:05am revealed he wonot exit his room while alarming.	vas sitting on his bed; he did			
	Interview with Resident #4 on 08/18/23 at 9:05am revealed: -He did not know what the alarm was forThere had been no fire drills at the facility since he moved in on 10/27/22. Refer to the interview with the SIC/Owner on 08/18/23 at 3:00pm.				
	Refer to the telephone Administrator on 08/2				
	11/07/22 revealed dia	t #5's current FL-2 dated gnoses included dementia turbance, hypertension, and			
	08/18/23 at 9:00am re -Resident #5 was am toward her room.	bulating in the hallway her bedroom during the fire			
	revealed: -She stayed where sh startedShe did not know wh started.	nt #5 on 08/18/23 at 9:02am we was when the noise at to do when the noise er practicing a fire drill.			
	Refer to interview with 08/18/23 at 3:00pm.	n the SIC/Owner on			

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STATE FORM 6899 E4Y611 If continuation sheet 16 of 141

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAVLODE	AMILY CADE LIOME #2	1136 BER	THA WILSON R	OAD		
IATLOR	FAMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 100	Continued From page	e 16	C 100			
	Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm.					
	3:00pm revealed: -She performed fire d -When a new residenthe resident if they he exit the closest doorWhen she performed set the alarm off, and respondedShe would tell the re still did not go out. Telephone interview w 08/21/23 at 4:43pm re -She was not aware t facility during fire drill -She asked the SIC/C	he residents did not exit the s. Owner if she was completing				
		ed any fire drills at the facility. or details about the fire drills,				
	fire rehearsals yearly knowing how to respo fire occur within the fa facility during a fire w	lity to conduct at least four resulted in the residents not and to a fire alarm should a acility nor how to exit the hich was detrimental to the ell-being of the residents and Violation.				
		rovide an acceptable plan of nce with G.S. 131D-34 on				
	A SUMMARY SUSPI	ENSION OF LICENSE WAS				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		501045040	B. WING		00/04/0000	
		FCL017018			08/21/2023	_
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA T HA WILSON R			
TAYLOR F	AMILY CARE HOME #2	BLANCH, I		OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	E
C 131	Continued From page	: 17	C 131			
C 131	10A NCAC 13G .0403 Medication Staff	8(a) Qualifications of	C 131			
	aides, and their direct training, clinical skills written examination a 131D-4.5B. Persons a occupational licensure medications are exem. This Rule is not met a Based on interviews a facility failed to ensure who administered me medication clinical ski documentation they h written state medication, and cor	e staff who administer r referred to as medication supervisors shall complete validation, and pass the s set forth in G.S. authorized by state e laws to administer opt from this requirement. as evidenced by: and record reviews, the e 2 of 3 sampled staff (B, C) dications, completed a ills checklist and had ad successfully passed the on administration oppleted the 5, 10, or ide (MA) training course or vious as a MA before				
	The findings are:					
	there was no record to documentation of commedication training, mothecklist or previous of the commedication training, mothecklist or previous of the commedication of the commendation of the com	personnel record revealed or review and no appletion of 5, 10, 15-hour nedication clinical skills employment verification. on 08/21/23 at 2:18pm assed the MA test when she ssisted the SIC/Owner when				

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STATE FORM 6899 E4Y611 If continuation sheet 18 of 141

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
	FCL017018	B. WING		08	3/21/2023
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR FAMILY CARE HOME #	1136 BE	RTHA WILSON RO	AD		
TATEOR FAMILI CARE HOME #	BLANCH	I, NC 27212			
PREFIX (EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
o7/30/23 and she amedications to the -She did not have a need one because few weeks. Interview with two recommendations when seed the seed one because few weeks. Interview with two recommendations when seed one because few weeks. Interview with two recommendations when seed one because few weeks. Interview with the Seed of the seed one of the seed on the s	as the in hospital overnight on administered the evening residents. A personnel record; she did not she would be going home in a sesidents on 08/21/23 at taff B administered she worked. SIC/Owner on 08/21/23 at cility, but it was closed. The requirements for a medication of the was certified to ions. It record was at her closed she needed to verify Staff B medications prior to cations to the residents, since and administered medications administered medications. Administrator on 08/21/23 at the of the SIC/Owner. A sick when she was in the connel record from previously at she had not brought the of this facility. Be had brought her personnel of the Administrator were king sure each staff had	C 131			

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STATE FORM 6899 E4Y611 If continuation sheet 19 of 141

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL017018	B. WING		08/21/2023
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BER	DRESS, CITY, STA		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 131	there was no record to documentation of commedication training, in checklist or previous. Telephone interview with 10:28am revealed: -She was a medication the SIC/Owner when -She cooked, administers of daily living (ADLs) -She worked at the fabut she did not administere worked at the facilityShe did not recall the medications, but it wayearShe had worked at a SIC/Owner's family medications to them with two research and the required linterview with two research and the revealed staff medications to them with the SIC 4:16pm revealed: -Staff C did not really -Staff C "just provided residents." -She knew she had to	sidents. sonnel records. spersonnel record revealed or review and no inpletion of 5, 10, 15-hour nedication clinical skills employment verification. with Staff C on 08/22/23 at on aide (MA) and assisted she was needed. Stered medications, took and assisted with activities as needed. Cility a couple of weeks ago, sister medications. In direction when she are last time she administered as since the beginning of the mother facility that the member owned. all her paperwork showing MA training. Sidents on 08/21/23 at a f C administered when she worked. COwner on 08/21/23 at do anything at the facility.	C 131		

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had the record and that was good enough.

STATE FORM 6899 E4Y611 If continuation sheet 20 of 141

DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			D 14//10			
		FCL017018	B. WING		08/2	21/2023
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	NOVIDEN ON SOIT LIEN					
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON F	ROAD		
		BLANCH	NC 27212			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	HAIE	DAIL
				,		
C 131	Continued From page	e 20	C 131			
		to the facility that many				
		think about needing to get				
	Staff C's record, and	then she would forget.				
		ministrator on 08/21/23 at				
	5:28pm revealed:					
	-She did not know wh					
		C/Owner to let her know				
	when new employees					
		required testing done prior				
	to working with the residents.					
	-She did not audit per	sonnel records.				
C 132	10A NCAC 13G. 0403	3(b) Qualifications Of	C 132			
	Medication Staff	o(z) Quamications of				
	modication otali					
	(h) Medication aides	and their direct supervisors,				
		orized by state occupational				
		ninister medications, shall				
	complete six hours of					
		edication administration.				
	annually related to me	edication administration.				
	This Dula is not most	an avidamend by				
	This Rule is not met					
		and record reviews, the				
	-	e 1 of 1 sampled staff (A)				
		dications had the required 6				
	hours of annual training	ng for medication				
	administration.					
	- · ·					
	The findings are:					
		ersonnel record revealed:				
	-She was hired in Apr	il 1985.				

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STATE FORM 6899 E4Y611 If continuation sheet 21 of 141

Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
			_			
			B. WING			
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
		1136 RFF	THA WILSON R	POAD		
TAYLOR F	AMILY CARE HOME #2		NC 27212			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
	i			DEFICIENCY)		
C 122	0	- 04	C 132			
C 132	Continued From page	3 21	C 132			
	-She was hired as a r	nedication aide.				
	-There was no documentation of continued					
	education since Nove	ember 2021 in the record.				
	1					
	Interview with Staff A	on 08/21/23 at 2:31pm				
	revealed:					
	-She was the Supervi	isor-in-Charge (SIC)/Owner				
	of the facility.					
	-She did not know the	e last time she had				
	medication administra	ation training.				
		on administration training				
	was offered through t	the facility's contracted				
	pharmacy.					
		all the pharmacy to schedule				
	a medication adminis	tration training class.				
	Interview with the Adr	ministrator on 08/21/23 at				
	4:41pm revealed:					
		ted pharmacy did the 6-hour				
	annual medication ad	S .				
		e last time the SIC/Owner				
		cation administration training.				
	·	e for ensuring the SIC/Owner				
	received her 6-hour m	nedication administration				
	training.					
	-She did not audit per	rsonnel records.				
	1					
C 145	10A NCAC 13G .0406	მ(a)(5) Other Staff	C 145			
	Qualifications					
	1					
	10A NCAC 13G .0406	6 Other Staff Qualifications				
	` '	n of a family care home				
	shall:					
		listed on the North Carolina				
		el Registry according to G.S.				
	131E-256;					
	1					

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This Rule is not met as evidenced by:

STATE FORM 6899 E4Y611 If continuation sheet 22 of 141

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		FCL017018	B. WING		08/2	1/2023
	ROVIDER OR SUPPLIER		RESS, CITY, STA			
IAILORI	AWILT CARE HOWE #2	BLANCH, N	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 145	Continued From page	22	C 145			
	TYPE B VIOLATION					
	facility failed to ensure	ews and interviews, the e 2 of 3 sampled staff (B, C) dings listed on the North Personnel Registry.				
	The findings are:					
	1. Review of Staff B's there was no personn	personnel record revealed el record to review.				
	revealed: -She had been visiting (SIC)/Owner since the -She owned a facility this timeShe would stay with SIC/Owner had appoint -She stayed with the ISIC/Owner would go walked away from the -The HCPR had not be arrived on 07/15/23She did not need the had previously owned Interview with the SIC	that was not in operation at the residents when the intments. residents when the look for a resident who had a home. Heen checked since she				
	-Staff B's HCPR was which was at the facil -She did not think she for Staff B since she p	facility, but it was closed. in her personnel record, ity that was now closed. e needed to check the HCPR				

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-Staff B was a relative of the SIC/Owner.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
		ECI 047049	B. WING		0.9/5	14/2022
		FCL017018			08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	,		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R I, NC 27212	COAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 145	Continued From page	e 23 SIC when she was in the	C 145			
	facility.	OIC WHEIT SHE WAS III THE				
	-Staff B had a person	nel record from previously				
	owning a facility but s personnel record to the	he had not brought the				
		for doing the HCPR check				
	on anyone who assis	ted with the residents.				
	-She did not audit per	rsonnel records.				
	2. Review of Staff C's there was no personn	personnel record revealed nel record to review.				
	Telephone interview v 10:28am revealed:	vith Staff C on 08/22/23 at				
		on aide and assisted the				
	SIC/Owner when she -She cooked, adminis	was needed. stered medications, took				
	residents on outings,	and assisted with activities				
	of daily living (ADLs)	as needed. cility a couple of weeks ago.				
		nat the HCPR was or if hers				
	had been checked.					
	Interview with the SIC 4:16pm revealed:	C/Owner on 08/21/23 at				
		do anything at the facility.				
	-Staff C "just provided residents."	d supervision to the				
		have a personnel record				
		ought her family member				
	had the record and the -Staff C did not come	at was good enough. to the facility that many				
		think about needing to get				
	Staff C's record, and	then she would forget.				
	Interview with the Adr 5:28pm revealed:	ninistrator on 08/21/23 at				
	-She did not know wh	o Staff C was. C/Owner to let her know				

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when new employees where hired.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING		08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	-	
TAYLOR F	AMILY CARE HOME #2		HA WILSON R	OAD		
		BLANCH, I	NC 27212		. 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 145	Continued From page 24		C 145			
	-She did not audit personnel records.					
	not have substantiate Health Care Personni working at the facility resulted in it being un substantiated findings detrimental to the hea the resident and cons	known if staff had s on the HCPR, which was alth, welfare, and safety of titutes a Type B Violation. NSION OF LICENSE WAS T 23, 2023.				
C 147	10A NCAC 13G .0406 Qualifications	6(a)(7) Other Staff	C 147			
	(a) Each staff person shall: (7) have a criminal bain accordance with Gavailable in the staff parallel in the staff parallel is not met TYPE B VIOLATION Based on record reviet facility failed to ensure	6 Other Staff Qualifications of a family care home ackground check completed a.S. 131D-40 and results person's personnel file; as evidenced by: ews and interviews, the e 2 or 3 sampled staff (B, C) round check completed upon				
	Review of Staff B's there was no personn	personnel record revealed				

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
						
			B WING			
		FCL017018	B. WING		08/2	21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		1136 BER	THA WILSON R	ROAD		
TAYLOR FAMILY CARE HOME #2		NC 27212	CAB			
		·	110 2/2/2			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETE
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPRO		DATE
IAG		,	170	DEFICIENCY)		
C 147	Continued From page	25	C 147			
	Interview with Staff B	on 08/21/23 at 2:18pm				
	revealed:	•				
	-She had been visiting	g the Supervisor in Charge				
	(SIC)/Owner since the	e 07/15/23.				
	-She had owned a fac	cility that was not in				
	operation at this time.					
	_	the residents when the				
	SIC/Owner had appoi					
	-She stayed with the					
	_	look for a resident who had				
	walked away from the					
		ackground check done				
	when she owned a fa	•				
	-She did not need to I					
	-	ne since she had one years				
	ago at the other facilit	ty.				
		C/Owner on 08/21/23 at				
	2:18pm revealed:					
	-She did not do a crin Staff B.	ninal background check for				
		facility, but it was closed.				
		ckground check was in her				
		ich was at the other facility				
	that was now closed.	ion was at the other rasmity				
		e needed to check Staff B's				
		since she previously had				
	one.	since she previously had				
	one.					
	Interview with the Adr	ministrator on 08/21/23 at				
	5:28pm revealed:					
	-Staff B was a relative	e of the SIC/Owner				
		SIC when she was in the				
	facility.	2.2				
		nel file from previously				
	·	she had not brought the				
	personnel record to the					
		for doing the criminal				
		n anyone who assisted with				

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the residents.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
			THA WILSON R		
TAYLOR F	FAMILY CARE HOME #2		NC 27212		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 147	Continued From page	e 26	C 147		
	-She did not audit personnel records. 2. Review of Staff C's personnel record revealed there was no personnel record to review. Telephone interview with Staff C on 08/22/23 at 10:28am revealed: -She was a medication aide and assisted the SIC/Owner when she was needed.				
	· ·	stered medications, took			
	residents on outings, and assisted with activities of daily living (ADLs) as needed.				
		as needed. cility a couple of weeks ago.			
		a criminal background had			
	been checked.				
		C/Owner on 08/21/23 at			
	4:16pm revealed:	de en de iner et the ferility			
	-Staff C "just provided	do anything at the facility.			
	residents."	a caper violent to the			
	-She knew she had to	have a personnel record			
		ought her family member			
	had the record and th	-			
		to the facility that many			
		think about needing to get then she would forget.			
	Stall C 3 record, and	men she would longer.			
	Interview with the Adr 5:28pm revealed:	ministrator on 08/21/23 at			
	-She did not know wh	no Staff C was.			
		C/Owner to let her know			
	when new employees				
	-She did not audit per	rsonnel records.			
	The facility failed to e	 nsure 2 of 3 staff had a			
		check completed prior to			
	hire. The facility's fail	ure resulted in it being			
	unknown if Staff B an	d Staff C had a criminal			

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history which was detrimental to the safety and

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
TAVI OP E	AMILY CARE HOME #2	1136 BER	THA WILSON R	OAD	
IAILORI	AMILI CARL HOME #2	BLANCH,	NC 27212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 147	Continued From page	e 27	C 147		
	welfare of the residents and constitutes a Type B violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023. A Plan of Protection was not obtained.				
C 148	10A NCAC 13G .0406 Qualifications	6 (a)(8) Other Staff	C 148		
	10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file;				
	This Rule is not met a	as evidenced by:			
	facility failed to ensure had an examination a	and record reviews, the e 2 of 3 sampled staff (B, C) and screening for the d substances completed			
	The findings are:				
	1. Review of Staff B's there was no personn	personnel record revealed nel record to review.			
	revealed:	on 08/21/23 at 2:18pm g the Supervisor in Charge e 07/15/23.			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		FCL017018	B. WING		08/2	1/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		HA WILSON R	COAD		
		BLANCH, N	IC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 148	Continued From page	2 8	C 148			
	-She had owned a factoperation at this timeShe would stay with SIC/Owner had appoidShe stayed with the instruction SIC/Owner would go walked away from the she had a drug screet facility, but it was now she did not need to have done since she had o owned a facility. Interview with the SIC 2:18pm revealed: -She did not do a drug staff B had owned a staff B's drug screen record, which was at a closedShe did not think she screen since she prevent since she prevent staff B was a relative staff B was a relative staff B was a relative staff B worked as a stacilityStaff B had a person owning a facility, but spersonnel record to the she was responsible screen was done beforesidentsShe did not audit per 2. Review of Staff C's	the residents when the intments. residents when the look for a resident who had home. en done when she owned a viclosed. have another drug screen one years ago when she C/Owner on 08/21/23 at g screen done for Staff B. facility, but it was closed. In would be in her personnel the facility that was now eneeded to do Staff B's drug viously had one. ministrator on 08/21/23 at e of the SIC/Owner. SIC when she was in the mel record from previously she had not brought the his facility. In for ensuring the drug one Staff B assisted with resonnel records.				
	there was no personn	•				

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Telephone interview with Staff C on 08/22/23 at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING		08/21	/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	OAD		
		BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 148	Continued From page 29		C 148			
	10:28am revealed: -She was a medication SIC/Owner when she she cooked, administ residents on outings, of daily living (ADLs) -She worked at the fareshe had not had a distarted working at this Interview with the SIC 4:16pm revealed: -Staff C did not really -Staff C "just provided residents." -She knew she had to for Staff C but she than the record and the record and the staff C did not come times, but she would Staff C's record, and staff C's record, and staff C's record and the staff C did not know when she expected the SI when new employees -She did not audit per The facility failed to e screening for the pressubstances was performed and compare the side of all residents and compare the staff (B and C) hired a was detrimental to the of all residents and compare the side of the sid	on aide and assisted the was needed. Stered medications, took and assisted with activities as needed. Cility a couple of weeks ago. Trug screen since she had a facility. COWner on 08/21/23 at do anything at the facility. Supervision to the approximate the facility member at was good enough. To the facility that many think about needing to get then she would forget. The Staff C was. COWner to let her know a where hired. The sonnel records.				
	A SUMMARY SUSPE ISSUED ON AUGUS					

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A Plan of Protection was not obtained.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	PLETED
		FCL017018	B. WING		08	8/21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ΓΕ, ZIP CODE		
T.).(1.05.5		1136 BER	THA WILSON R	OAD		
IAYLOR F	AMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 171	For Licensed Health 10A NCAC 13G .0504 and Validation For Lic Support Tasks (a) When a resident personal care tasks li (1) through (a)(28) of Subchapter, the task non-licensed staff or lin their licensed capa	may be delegated to icensed staff not practicing city after a licensed health lated the staff person is	C 171			
	This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled staff (A) had documentation of a completed Licensed Health Professional support tasks competency validation prior to performing blood pressure checks. The findings are: Review of Staff A's personnel record revealed: -She was hired in April 1985She was the Supervisor-in-Charge (SIC)/OwnerShe was hired as a medication aideThere was a Licensed Health Professional Support (LHPS) tasks competency validation dated 07/15/23Staff A had not been validated for vital signs (including blood pressure checks).					

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DIVISION	n Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		FCL017018	B. WING		00/2	1/2023
		1 02017010			1 00/2	. 1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
TAVI OD E	AMILY CARE HOME #2	1136 BE	RTHA WILSON R	OAD		
IAILUKI	AMILY CARE HOME #2	BLANCH	I, NC 27212			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ı	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	MAIE	DATE
				,		
C 171	Continued From page	e 31	C 171			
	Interview with the Sta	ff A at 08/21/23 at 2:52pm				
	revealed:	/ . а о./ / _ о а о _ р				
	-She knew how to che	eck a resident's blood				
	pressure.					
	-She had been taking	blood pressures for years.				
	-	ELHPS validation form did				
	not assess her ability	to check a resident's blood				
	pressure.					
		o owned a business, and her				
	friend came to check					
	competency validation					
		he LHPS validation was				
	different from the med	dication checklist.				
	Interview with the Adr	ministrator on 08/21/23 at				
	4:41pm revealed:					
	•	rmacist from the facility's				
	contracted pharmacy	completed the LHPS				
	validation for the facil					
	•	one else came to the facility				
	to train the facility sta					
		he SIC/Owner had not been				
	validated to check blo	•				
	record.	SIC/Owner's personnel				
	record.					
0.405	404 NOAO 400 000	1/a) Managamant 1 Ott	0.105			
C 185		1(a) Management and Other	C 185			
	Staff					
	10A NCAC 13G 060	1Mangement and Other				
	Staff					
		ne administrator shall be				
	•	tal operation of a family care				
	home and shall also b					
		rvice Regulation and the				
		social services for meeting				
		ules of this Subchapter.				
	The co-administrator,	when there is one, shall				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING: _			
		FCL017018	B. WING		08	/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2	1136 BERT BLANCH,	THA WILSON R NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 185	for the operation of th	bility with the administrator the home and for meeting ules of this Subchapter. or also refers to	C 185			
	reviews, the Administ total operation of the rules for family care hentrances and exits, of safety and disaster pladministration, person health care, nutrition storage, controlled sumedication staff, other competency validation resident assessment, professional support, rights, medication or disasterior of the summedication or disasterior of the summedication of t	ns, interviews, and record rator failed to ensure the facility to meet and maintain tomes related to outside design and construction, fire an, medication nal care and supervision, and food service, medication obstances, qualifications of er staff qualifications, in for licensed health,				
	Observation of the factors of the factors of the facility. Interview with the Supplement of the Administrator capevery 2 months. -The Administrator states of the factors	evealed five residents were				

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R , NC 27212	OAD	
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (V5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 185	5 Continued From page 33		C 185		
	roomsThe Administrator has since the newest residuality in June 2023. Telephone interview wo 08/18/23 at 4:46pm re-She had not been to -She went to the facility-She usually talked to telephone or video or Interview with two researched.	the facility in about a month. ity every "two months or so." the SIC/Owner by nce or twice a week. idents on 08/21/23 at hyone at the facility by the			
	2:12pm and 3:19pm r -The Administrator wa -She had to show the the facility on 08/19/2 Administrator got lost Telephone interviews 08/21/23 at 3:34pm a -She thought the facil -She did not know the offShe was not aware t facility during fire drills -She had not observe -She did not audit res records.	As at the facility on 08/19/23. Administrator how to leave 3, because the trying to find the facility. with the Administrator on and 4:43pm revealed: ity had door alarms. e alarms had been turned the residents did not exit the			

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facility someone drove her; she stayed about 1.5

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE SUR COMPLETE				
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO	AD		
	OLINA NA DVOT		I, NC 27212	DDOV/DEDIG DI AN OF	- CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 185	Continued From page	e 34	C 185			
	hours.					
	Non-compliance was rule areas:	identified in the following				
	facility failed to ensural alone in the facility wi [Refer to Tag 186 10.4 Management and Oth VIOLATION)]. 2. Based on observareviews, the facility fa accordance with the reare plan and current sampled residents (##1, who had a history known to wander from the Supervisor-in-Chaleaving the facility mu 08/21/23; and Reside of dementia and was physically abusive to supervised when she was observed lighting (#5). [Refer to Tag 24 Personal Care And S	tions, interviews, and record illed to provide supervision in residents' assessed needs, symptoms for 2 of 5 1, #5) related to Resident of mental illness and was in the facility and away from large (SIC) when on outings, altiple times on 08/18/23 and left #5, who had a diagnosis reported to have been other residents and was not went outside to smoke and g cigarettes inside the facility 43 10A NCAC 13G .0901(b)				
	interviews, the facility medications as ordered residents (#1, #2, and anti-psychotic medication used to contain a medication for elevation for elevation interviews, the facility medication for elevation for elev	ed for 3 of 3 sampled d #3) including an ation (#1); a diabetic ontrol blood sugars (#2); and ated blood pressure (#3). A NCAC 13G .1004(a)				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			' '	(3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08	3/21/2023	
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BEI	DDRESS, CITY, STATE RTHA WILSON RO. I, NC 27212				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
C 185	Continued From page	35	C 185				
	reviews, the facility farevacuation capabilities the evacuation capabilities and current license for 1 c who had a diagnosis respond to the fire dri NCAC 13G .0302(b) (TYPE B VIOLATION) 5. Based on observat reviews, the facility fa doors accessible to reaway from the facility was sometimes disor alarms that were of sibe heard by staff whe to for the safety of the 069 10A NCAC 13G and Exits (TYPE B VIOLATION) 6. Based on record refacility failed to ensure rehearsed at least to Tag 100 10A NCAC And Disaster Plan (TYPE). Based on record refacility failed to ensure had no substantial fin Carolina Health Care to Tag 145 10A NCAC Staff Qualifications (18. Based on record refacility failed to ensure had a criminal backgritism.	ions, interviews, and record iled to ensure 2 of 2 exit esidents, who wandered (#1) and a resident who sented (#5), had working ufficient volume that could in activated and responded eresidents. [Refer to Tag 0312(g) Outside Entrance OLATION)]. Eviews and interviews, the exit four times yearly. [Refer C 13G .0316(e) Fire Safety YPE B VIOLATION)]. Eviews and interviews, the exit of a sampled staff (B, C) dings listed on the North Personnel Registry. [Refer C 13G .0406(a)(5) Other TYPE B VIOLATION)]. Eviews and interviews, the exit of a sampled staff (B, C) ound check completed upon 7 10A NCAC 13G .0406(a)					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR I	FAMILY CARE HOME #2	1136 BE	RTHA WILSON RO	AD		
IAILOKI	AWIET CARE HOWE #2	BLANCH	I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 185	Continued From page	e 36	C 185			
	VIOLATION)].					
	facility failed to ensur had an examination a presence of controlled upon hire. [Refer to T. .0406(a)(8) Other Sta VIOLATION)]. 9. Based on observat reviews, the facility fa for 1 of 4 sampled res fingernails and toenal trimmed. [Refer to Ta. .0901(a) Personal Ca B VIOLATION)].	d substances completed ag 148 10A NCAC 13G off Qualifications (TYPE B dions, interviews, and record off illed to provide personal care sidents (#5) related to fils that needed to be g 242 10A NCAC 13G off and Supervision. (TYPE dations, interviews, and				
	sampled residents (## needed their toenails	acility failed to refer 1 of 3 2) who was a diabetic and trimmed, to a podiatrist. A NCAC 13G .0902(b) 5 VIOLATION)].				
	reviews, the facility fa orders were impleme residents (#1, #2) rela sugar monitoring for a diagnosis of diabetes checks for a resident	(#1); and blood pressure who had a diagnosis of efer to Tag 249 10A NCAC				
	facility failed to proted	ws and record reviews, the ct two residents (#1, #4) from esident and failed to ensure eated with dignity and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		'	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL017018	B. WING		08/2	21/2023
NAME OF PROVIDER O	OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
TAYLOR FAMILY C	ARE HOME #2		THA WILSON R NC 27212	ROAD		
1 1 1 1/1	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
respect other. [Reside 13. Bas intervier readily substant administresident to treat .1008(a VIOLA 14. Bas facility who admedical document written examinate medical administrage 13 of Med 15. Bas facility who administrage 13 of Med 15. Bas facility who administrage 14. Bas facility who administrage 15. Bas facility who administrage 16. Bas facility who administrage 17. Bas facil	Refer to Tag 3 ant Rights (TYF) sed on observatives, the facility retrievable reconces by documstration, and did (#1) with an anxiety. [Refer a) Controlled STION)]. Sed on intervier failed to ensure the medication they have the medication and contion aide (MA) attion of previous terring medication. Staff (State on intervier failed to ensure the medication of the properties of annual training stration. [Refer of annual training the properties of annual training the properties of annual training stration. [Refer of annual training the properties of the proper	idents arguing with each 11 10A NCAC 13G .0909 PE B VIOLATION)]. ations, record reviews, and failed to ensure there were cords for controlled menting the receipt, sposition for 1 of 1 sampled order for a medication used or to Tag 367 10A NCAC 13G substances (TYPE B ws and record reviews, the e 2 of 3 sampled staff (B, C) dications, completed a sills checklist and had had successfully passed the on administration expleted the 5, 10, or 15-hour training course or had as as a MA before tion to residents. [Refer to 3G .0403(a) Qualifications standard Deficiency)]. ws and record reviews, the e 1 of 1 sampled staff (A) dications had the required 6 and for medication to Tag 132 10A NCAC 13G is of Medication Staff	C 185			

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		FCL017018	B. WING		08	8/21/2023
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BE	ADDRESS, CITY, STATE RTHA WILSON RO 1, NC 27212		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 185	checks. [Refer to Tag. 0504(a) Competency Health (Standard Def 17. Based on record facility failed to ensur was completed within using the Resident Reresidents (#1, #2, and NCAC 13G .0801(a) (Standard Deficiency) 18. Based on intervie facility failed to ensur within 30 days of adm residents (#2, #3). [R 13G .0801(b) Residents (#2, #3). [R 13G .0801(b) Residents (#2, #3) ampled resident developed the sampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (#2, #3). [R 13G .0801(b) Resident developed the sampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents (fingerstick blood sugato Tag 254 10A NCAC Health Professional Stampled residents	171 10A NCAC 13G (Validation for Licensed iciency)]. reviews, and interviews, the e that an initial assessment 172 hours of admission egister for 3 of 3 sampled 173). [Refer to Tag 230 10A Resident Assessment 19]. ws and record reviews, the e a care plan was completed hission for 2 of 3 sampled efer to Tag 231 10A NCAC 199 and 199	C 185			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	,	
TAYLOR F	AMILY CARE HOME #2	1136 BER	THA WILSON R	OAD		
IAILORI	AWIET CARE HOWE #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 185	Continued From page 39		C 185			
	residents three times a day. [Refer to Tag 272 10A NCAC 13G .0904(d)(2) Nutrition and Food Service (Standard Deficiency)]. 22. Based on observation, record reviews, and interviews, the facility failed to ensure a listing of residents with physician-ordered therapeutic diets was available for the guidance of the facility staff for 1 of 1 sampled resident with an order for an HHCC diet (#2). [Refer to Tag 283 10A NCAC 13G .0904(e)(3) Nutrition and Food Service (Standard Deficiency)]. 23. Based on observations, interviews, and record reviews, the facility failed to ensure a nutritional supplement was served to 1 of 1 sampled residents (#2) as ordered by the Primary Care Provider (PCP) when the resident ate less than 50% of their meal. [Refer to Tag 284 10A NCAC 13G .0904(e)(4) Nutrition and Food Service (Standard Deficiency)].					
	interviews, the facility were provided to pror involvement and enga resided in the facility.	aged the residents who [Refer to Tag 288 10A				
	NCAC 13G .0905(a) Activities Program (Standard Deficiency)]. 25. Based on interviews and record reviews, the facility failed to immediately notify the Department of Social Services (DSS) for 1 of 1 sampled residents (#1), who had a history of mental illness and wandered away from the facility on 08/18/23, and was gone more than 8 hours and the facility did not know the whereabouts of the resident. [Refer to Tag 301 10A NCAC 13G .0906(f)(4) Other Resident Services (Standard Deficiency)].					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		FCL017018	B. WING		08	3/21/2023
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BEF	DDRESS, CITY, STATE RTHA WILSON RO. I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 185	26. Based on record of facility failed to contact (PCP) for 2 of 3 samp clarification of orders and a stool softener (NCAC 13G .1002(a) It (Standard Deficiency) 27. Based on observer record reviews, the famedication administrator 2 of 3 sampled resemedication for involute diuretic, a hormone reanxiety medication, a medication for depressor reflux (#3). [Refer .1004(j)Medication Or 28. Based on observation in a locked container. NCAC 13G .1006(b) It (Standard Deficiency) 29. Based on observation for a double lock. [13G .1008(b) Control Deficiency)]. 30. Based on record facility failed to ensure who administered mestate-mandated infections.	reviews and interviews, the cet the Primary Care Provider oled residents (#1, #3) for for an anti-psychotic (#1) #3). [Refer to Tag 315 10A Medication Orders old.]. ations, interviews, and incility failed to ensure the ation records were accurate of sidents (#1, #3) including a netary movements (#1); and a replacement medication, an blood pressure medication, and two medications to Tag 342 10A NCAC 13G orders (Standard Deficiency)]. ation, record review, and failed to ensure of residents (#3) were stored of [Refer to Tag 353 10A Medication Storage old.]. ations and interviews the electronic controlled medication, ety medication, was stored of [Refer to Tag 368 10A NCAC old Substances (Standard old Substances old Substances (Standard old Substances old Substances (Standard old Substances old Substances old Substances (Standard old Substances	C 185			

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Division of	<u>of Health Service Regu</u>	lation				
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		FCL017018	B. WING		08/2	1/2023
			-		1 00/2	172020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	OAD		
		BLANCH,	NC 27212			
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
,,,,		,	, ,,,	DEFICIENCY)		
C 10E	O	- 44	C 185			
C 185	Continued From page	e 41	C 165			
	The Administrator failed to ensure the overall					
		ons, and policies of the				
		nted by failing to ensure a				
	, ,	indered and was adjudicated				
		the facility unsupervised on				
		thout staff knowing her				
		it (#5) fighting and arguing				
	•	n the facility or intervening;				
		d exits had alarms that				
		d when opened to alert staff ft the facility (#1) and a				
		oriented had exited the				
		were performed so the				
	- , ,	how to evacuate in the				
		ations were administered as				
	ordered to a resident					
	medication had not be	een discontinued after				
	having increased hall	ucinations, a resident who				
	was diabetic had not	received his medication to				
	lower his blood sugar	s and another resident had				
		d pressure medication				
		13 tablets of a controlled				
	medication unaccoun					
	•	PS tasks for two residents				
		ure (#2) and fingerstick				
		#1). This failure of the				
		d in serious neglect of the				
	residents which consi	titutes a Type A1 Violation.				
	The facility failed to n	rovide an acceptable plan of				
		nce with G.S. 131D-34 on				
	08/21/23.					
	<u>.</u> <u></u>					
	A SUMMARY SUSPE	ENSION OF LICENSE WAS				
	ISSUED ON AUGUS					
C 186	10A NCAC 13G .060	1 (b)(1) Management And	C 186			
	Other Staff	· · · · · · · · · · · · · · · · · · ·				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SI COMPLE	
		FCL017018	B. WING		08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R	OAD		
			, NC 27212		- 1	
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 186	Continued From page 42 10A NCAC 13G .0601 Management And Other Staff		C 186			
	or supervisor-in-charge responsible for assuring are carried out in the at no time is a resider without a staff member cited in Paragraph (c) occasional absence of supervisor-in-charge, arrangements shall be (1). The administrator reside within 500 feet of two-way telecommal times. When the at the licensed home, the staff member who live each shift and the administrator the staff member who live each shift and the administrator the licensed home, the staff member who live each shift and the administrator the licensed home, the staff member who live each shift and the administration of the licensed home, the staff member who live each shift and the administration of the license home.	ng that all required duties home and for assuring that ht left alone in the home er. Except for the provisions of this Rule regarding the of the administrator or one of the following e used: r shall be in the home or of the home with a means unication with the home at administrator does not live in ere shall be at least one es in the home or one on ministrator shall be directly ng that all required duties				
	This Rule is not met a	-				
		ns and interviews, the facility esidents were not left alone supervision of staff.				
	The findings are:					
	Observations of the fa	acility on 08/18/23 revealed:				

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-At 9:19am, the Supervisor-in-Charge

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/2	1/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR	FAMILY CARE HOME #2	1136 BERT BLANCH,	THA WILSON R NC 27212	COAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 186	(SIC)/Owner came in private residence to puthe residents and returns idented and shut the residents alone. -At 9:34am, the SIC radminister medication. Observation of the factor administer medication. Observation of the resides SIC/Owner's private runch plates, and returns plates, an	to the facility from her provide the breakfast meal to provide the breakfast meal to provide the private and provide the private and provide the adjoining door, leaving the eturned to the facility to ans. Cility on 08/18/23 revealed: ents entered the residence, picked up their provide to the dining room in the provide the residents. Sidents' living quarters on everaled: eseated in the residents' living through the kitchenette to ecting the residents' living water's house. In the door and requested the provided the resident with a standard the door to the SIC//Owner's back to the living room and	C 186			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:			
		FCL017018	B. WING		08/:	21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE			
TAYLOR F	AMILY CARE HOME #2		THA WILSON R NC 27212	ROAD			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETE DATE	
C 186	Observation of the facility on 08/21/23 from 8:41am to 8:47am revealed there was no facility staff in the facility and the door to the SIC/Owner's private residence was closed. Interview with a resident on 08/18/23 at 2:26pm revealed: -The SIC/Owner stayed on her side of the house and would come to the facility during meals and to administer medicationsIf a resident needed something, they would knock on the SIC/Owner's door. Interview with another resident on 08/18/23 at 11:34am revealed: -The SIC/Owner was always in her private residence with the adjoining door closedThe only time the SIC/Owner was in the facility was at breakfast, lunch, and dinner.		C 186				
	revealed: -She did not see anyo over the weekend, just	ed in her house, which was					
	9:35am and 4:25pm r -The SIC/Owner's fan facility on 08/19/23 bu nightNo one else stayed i 08/18/23, or Sunday, -The last time he saw was between 8:00pm	nily member stayed in the ut did not stay any other n the facility on Friday, 08/20/23, but the residents. Ithe SIC/Owner each night and 9:00pm.					
	Interview with a third 12:15pm revealed:	resident on 08/21/23 at					

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	1136 BEI		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2	1136 BE	RTHA WILSON RO	AD		
		BLANCI	H, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 186	Continued From page	e 45	C 186			
	-He got up every night (08/18/23-08/20/23).	nt over the weekend only people he saw in the				
	facility were two othe					
	_	ne in the living room area of vent outside during the night.				
	Interview with a fourth resident on 08/21/23 at 2:00pm revealed on 08/21/23, between 12:00am					
		t down the hallway and				
	looked in the living room and there were two residents in the living room, but no staff member.					
	2:12pm and 3:16pm -She was not in the facilit afternoon to cleanShe was not in the fa the residents up for b -She was in the facilit minutesAll the residents in h -She was in the facilit and 1 to 2 hours in th -She could not be are smoked.	acility 24/7. ty for about an hour each acility every morning to wake breakfast. ty about every 30-45 her facility were independent. ty all the time in the morning				
	over and check on th	re residents every 30 to 45 ay and the evening hours.				
	08/18/23 at 5:40pm r supervision to the res	with the Administrator on revealed staff would provide sidents at all times, awake il an alarm system could be				
	08/21/23 at 3:34pm a	with the Administrator on and 4:43pm revealed: as going to be in the resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2	1136 BERT BLANCH, N	HA WILSON R NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 186	Continued From page 46		C 186			
	facilty and the staff corresidents Refer to Tag 0069, 10 Entrance and Exits (T	uld be in the private the door was open to the buld periodically chick on the DA NCAC 13G .0312 Outside Type B Violation). A NCAC 13G .0901(b)				
	Refer to Tag 311, 10A Rights (Type B Violation The Administrator and failed to ensure a staff at all times to provide and to ensure the require implemented, rewandering from the fawithout staff's knowle amongst the residents serious neglect of the a Type A1 Violation.	d/or Supervisor-in-Charge If member was in the facilty supervision to the residents uired duties of the facility esulting in a resident acility on multiple occasions dge and arguing and fighting s. This failure resulted in residents, which constitutes				
	A Plan of Protection v	vas not obtained.				
C 230	10A NCAC 13G .080 ² (a) A family care hom	1 (a) Resident Assessment 1 Resident Assessment ne shall assure that an initial resident is completed within n using the Resident	C 230			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		'	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74157 2747	or definition	A. BUILDING:		00111112125		
		FCL017018	B. WING		08/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2	1136 BER BLANCH,	THA WILSON R NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉT	ſΕ
C 230	O Continued From page 47		C 230			
	facility failed to ensure was completed within	ews, and interviews, the e that an initial assessment 72 hours of admission egister for 3 of 3 sampled				
	The finding are: 1. Review of Resident #1's current FL-2 dated 11/29/22 revealed diagnoses included diabetes mellitus type 2, schizophrenia, hypothyroidism, hypertension, and vitamin D deficiency.					
	revealed: -Resident #1 was adr -Resident #1's Reside checked but there wa number listed for the -Resident #1's persor checked, then whited still visible.	ent Register had "guardian" s no name or phone				
	-She did not know Re Register was not sign	1/23 at 2:31pm revealed: esident #1's Resident ned. e for completing and signing				
	Administrator on 08/2 2. Review of Residen 05/19/23 revealed dia	1/23 at 4:41pm. t #2's current FL-2 dated				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED
		FCL017018	B. WING			8/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
TAVI OD E	FAMILY CARE HOME #2	1136 BE	RTHA WILSON RO	AD		
IAILORI	AMILI CARE HOME #2	BLANCH	H, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 230	Continued From page	e 48	C 230			
	personality disorder,	and anxiety disorder.				
		2's Resident Register o resident register available				
		papers from an inpatient ospital revealed Resident #2 e facility on 05/22/23.				
	2:12pm revealed:	C/Owner on 08/21/23 at				
	-Resident #2 was his	own responsible party and ent had signed the Resident				
	Refer to the telephon Administrator on 08/2					
	06/07/23 revealed dia	t #3's current FL-2 dated agnoses included bipolar nia, and post-traumatic				
	revealed:	3's Resident Register				
	checked with the nam	mitted on 06/07/23. ent Register had "guardian" ne and telephone number of				
	his guardianResident #1's Resident by his guardian or the	ent Register was not signed e Administrator.				
	2:31pm revealed:	C/Owner on 08/21/23 at				
	Department of Social	an was not from the local Services. ent Resident #3's Resident				

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	OF DEFICIENCIES OF CORRECTION					
		FCL017018	B. WING		08	/21/2023
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BEI	DDRESS, CITY, STATE RTHA WILSON ROA I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 230	Register was not sign Refer to the telephone Administrator on 08/2 Interview with the Adr 4:41pm revealed: -The Resident Regist signed within 72 hour -The SIC/Owner and responsible for having completed and signed	an for signature. an sent the Resident ed. I-up to see why the Resident ed. e interview with the 1/23 at 4:41pm. ministrator on 08/21/23 at er should be completed and s. the Administrator were g the Resident Register d within 72 hours. do record audits; she may	C 230			
C 231	10A NCAC 13G .080° (b) The facility shall a each resident is comp following admission a thereafter using an as established by the Department of the established on th	and at least annually assessment instrument artment or an instrument artment based on it as same information as lished instrument. The appleted within 30 days and annually thereafter shall asment to determine a actioning to include and, cognitive status and an activities of daily living. It is a compared to the composition of locomotion, activities of locomotion,	C 231			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		THA WILSON R NC 27212	OAD		
		·	NC 2/2/12			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE	
C 231	Continued From page	e 50	C 231			
	referral to the resident licensed health care	professional, a provider of opmental disabilities or				
	facility failed to ensur	as evidenced by: and record reviews, the e a care plan was completed nission for 2 of 3 sampled				
	The findings are:					
	05/19/23 revealed dia	r type, schizoaffective				
		papers from an inpatient ospital revealed Resident #2 e facility on 05/22/23.				
	-The care plan had be dated with an assess -The care plan was n in Charge (SIC)/Own	ot signed by the Supervisor er. ot signed by Resident #2's				
	2:12pm revealed: -She was responsible #2's care plan.	C/Owner on 08/21/23 at e for completing Resident esident #2's care plan to the				

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	ND PLAN OF COPPECTION IDENTIFICATION NUMBER		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3)		
		FCL017018	B. WING		08	/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON R , NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 231	06/07/23 revealed dia disorder, schizophren syndrome disorder. Review of Resident # was no care plan to re Interview with the SIC 2:31pm revealed: -Resident #3 was indehimselfShe was responsible plans for Resident #3 -She did not remember Resident #3. Refer to the telephone Administrator on 08/2 Telephone interview wo 08/21/23 at 4:41pm re -The SIC/Owner was the care plan and have daysThe SIC/Owner would PCP for signature wit visitShe had not audited	e interview with the 1/23 at 4:41pm. It #3's current FL-2 dated agnoses included bipolar ia, and post-traumatic 3's care plan revealed there eview. It would be interview. It would be interview with the 1/23 at 4:41pm. It with the Administrator on	C 231			
C 242	10A NCAC 13G .090 ⁻² Supervision	1(a) Personal Care and	C 242			
	10A NCAC 13G .090	1 Personal Care and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL017018	B. WING		08	3/21/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	. ZIP CODE		
			RTHA WILSON RO			
TAYLOR	FAMILY CARE HOME #2	BLANCH	, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 242	Supervision (a) Family care home care to residents accorplans and attend to an needs residents may themselves. This Rule is not met TYPE B VIOLATION Based on observation reviews, the facility fa for 1 of 4 sampled resingernails and toenait trimmed. The findings are: Review of Resident # 11/07/22 revealed diawithout behavioral dishyperlipidemia. Review of Resident # 11/07/22 revealed: -Resident #5 was son-Resident #5 had sign must be directed. Observation of Resident # 11:07am revealed: -The first toenail on he multiple places in the -The toenail on her seend of the toe and was -The toenails on her textended past the eninch and were turning	e staff shall provide personal ording to the residents' care my other personal care be unable to attend to for as evidenced by: as, interviews, and record iled to provide personal care sidents (#5) related to ls that needed to be 5's current FL-2 dated agnoses included dementia sturbance, hypertension, and 5's Care Plan dated netimes disoriented. nificant memory loss and ent #5's toenails on 08/18/23 er left foot was broken in nail bed. econd toe extended past the is broken.	C 242			

Division of Health Service Regulation

STATE FORM 6899 E4Y611 If continuation sheet 53 of 141

DIVISION	of Health Service Regu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL017018	B. WING		08/21/2023
		1 02017010			00/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
TAVI OD 5	*******	1136 BEF	RTHA WILSON R	OAD	
IAYLOR	AMILY CARE HOME #2	BLANCH	, NC 27212		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEI IGIENCI)	
C 242	Continued From page	2 53	C 242		
	The first toenail on h	er right foot was broken and			
	jagged.	er right loot was broken and			
		ther toes extended past the			
		urth of an inch and they			
		•			
	were thick and pointe	u.			
	Observation of Resid	ent #5's fingernails on			
	08/21/23 at 8:26am re	•			
		ded past the end of her			
	fingers three-quarters				
		er thumbs were broken and			
	jagged.	er thumbs were broken and			
		had a buildup of grime and			
	dirt underneath each	· -			
	unt underneam caon	nan.			
	Interview with Reside	nt #5 on 08/18/23 at			
	11:10am revealed:				
	-She could not cut he	r nails.			
		ince anyone had cut her			
	nails, toenails, or fing				
	_				
	Telephone interview v	vith Resident #5's legal			
	guardian on 08/21/23	at 8:45am revealed:			
	-She saw Resident #5	5 at the facility on 07/17/23.			
	-Resident #5 had a di	agnosis of dementia.			
	-She expected the fac	cility staff to make sure daily			
	care including assista	ince with hygiene and			
	showers was done.				
	-She would expect the	e facility staff to take care of			
	Resident #5's toenails	s and fingernails during			
	showers and persona	ıl care.			
	-She had spoken to the	ne Supervisor in Charge			
	(SIC)/Owner on 07/17	7/23 about Resident #5's			
		ils needing to be trimmed.			
		onded that Resident #5 cut			
	her nails, but they wo				
		Resident #5's toenails and			

safety concern.

fingernails had still not been cut because it was a

-Resident #5 could cut herself or she could also

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DIVISION	<u>of Health Service Regu</u>	lation				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURV COMPLETED	
		FCL017018	B. WING		08/21/2	.023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON R , NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
C 242	experience an ingrow discomfortResident #5's fingerr cleaned for hygienic rouse of the resident #5's toenails and fingeresident #2 could acpossibly scratch some get infectedIf Resident #2's toenaresident could experie with walking. Interview with the SIC 2:12pm revealed: -If a resident was not their own toenails and -If the resident neede could ask her for the experience with walking. Interview with the SIC 2:12pm revealed: -If a resident was not their own toenails and -If the resident #5 could not -Resident #5 said she fingernailsShe recalled Resident mentioned the resident resident #5's nails we to order something to -The clippers she order toenails had "just been linterview with the Adra 4:43pm revealed:	n toenail which could cause nails also needed to be easons. with Resident #5's Primary) nurse on 08/21/23 at e facility staff to cut Resident ernails. cidentally scratch herself or eone else, which could then ails were not cut the ence pain and discomfort E/Owner on 08/21/23 at a diabetic, the resident cut if fingernails. d clippers, the resident cut if clippers. of cut her toenails. e was going to cut her nt #5's legal guardian had int's nails needed to be cut. were thick, and she needed cut her nails with. ered to cut Resident #5's	C 242			

-If Resident #5's toenails were thick, the resident

would need to be taken to a podiatrist. -When Resident #5 was assisted with her

STATE FORM 6899 E4Y611 If continuation sheet 55 of 141

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		FCL017018	B. WING		08	3/21/2023
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2		DDRESS, CITY, STATE			
IAILOKI	AMILI CARL HOME #2	BLANCH	I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 242	shower, the resident's clipped and kept clea The facility failed to e diagnosis of dementia disoriented with signif received the assistan toenails and fingernai resident having long, fingernails, which put risk of injury. This fail resident's health, safe constitutes a Type B	s fingernails should be n. Insure a resident who had a a and was sometimes be ficant memory loss (#5), ce she needed trimming her ils, which resulted in the jagged toenails and the resident an increased ure was detrimental to the ety and welfare and Violation. ENSION OF LICENSE WAS T 23, 2023.	C 242			
C 243	Supervision 10A NCAC 13G .090 Supervision (b) Staff shall provide accordance with each care plan and current This Rule is not met TYPE A1 VIOLATION Based on observation reviews, the facility far accordance with the reare plan and current sampled residents (##1, who had a history known to wander from	e supervision of residents in resident's assessed needs, symptoms. as evidenced by: Ins, interviews, and record illed to provide supervision in residents' assessed needs,	C 243			

Division of Health Service Regulation

STATE FORM 6899 E4Y611 If continuation sheet 56 of 141

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
		FCL017018	B. WING		08	8/21/2023
NAME OF PROVIDER OF	SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
TAN/ OD FAMILY OA	DE 110ME #0	1136 BEF	RTHA WILSON RO	AD		
TAYLOR FAMILY CA	RE HOME #2	BLANCH	, NC 27212			
	ACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
leaving to 8/21/23 of demeny hysicall supervis was obsequent was obsequent of the finding supervis was obsequent of the finding supervis of the fact and the resident of the fact and the resident of the fact and the resident of the fact and	is; and Residentia and was y abusive to ed when she erved lighting are: w of the faciliar revealed: elity's resident #1, her legarator. Is and accompliant and accompliant sign out any resident are softhe local elity was not a grading off the facility was not a grading respectively was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents and the possibility was not a precautions are residents.	ultiple times on 08/18/23 and ent #5, who had a diagnosis reported to have been other residents and was not a went outside to smoke and g cigarettes inside the facility dity's resident contract dated at contract was not signed by all guardian, or the sidents on a 24-hour basis. Seed and wandering residents to who desired to leave the and inform two staff tion visiting and expected cility was prohibited without set for the rights of others. It allocked door facility; had been taken to help did not wander from the collity remained that someone in the facility type 2, ertension, and vitamin D	C 243			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		1136 BER	THA WILSON R	OAD	
IAYLOR F	AMILY CARE HOME #2	BLANCH,	NC 27212		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 243	Continued From page	e 57	C 243		
	-There were no behav	viors noted.			
	Review of Resident #1's Resident Register revealed: -There was an admission date of 05/11/21.				
	-Resident #1 had a g	uardian.			
	Review of Resident #1's legal documents revealed the court adjudicated Resident #1 incompetent and appointed the county				
	guardian for Resident	Services (DSS) as the t #1 on 12/03/21.			
	revealed:	1's care plan dated 11/29/22			
		istory of mental illness. d medication for mental			
		en by Mental Health (MH). viors noted.			
		:1's record on 08/18/23 no incident/accident reports w.			
	Review of Resident # dated 03/27/23 revea	:1's MH Provider's visit note led:			
	Resident #1 had been week related to parar				
	-Resident #1 demons	trated paranoid thoughts.			
	dated 05/02/23 revea	:1's MH Provider's visit note led: d "the people upstairs stole			
		trated paranoid thoughts.			
	Review of Resident #	: 1's MH Provider's visit note			

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dated 06/19/23 revealed Resident #1 reported

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	or riealth Service Regu				Tayes =	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE S	
VIAD LEWIN (J. GOMMEGHON	IDENTIFICATION NUMBER.	A. BUILDING: _		COIVIPL	LILU
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		1136 BER	THA WILSON R	ROAD		
TAYLOR F	AMILY CARE HOME #2		NC 27212			
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
C 243	Continued From page	÷ 58	C 243			
	hearing voices comin	g from rooms in the facility.				
	ricaring voices commi	g nom rooms in the lasinty.				
		1's MH Provider's visit note				
	dated 08/03/23 revea					
		d ongoing hallucinations and				
	depression.	doing well due to group				
	home situation.	doing well due to group				
		uctant to increase selective				
	serotonin reuptake in					
	(anti-depressants used to treat persistent or					
	severe depression) de	ue to history of worsening				
	psychosis on SSRI m	edications.				
	Review of a law enfor	cement report dated				
	06/23/22 revealed:	coment report dated				
	-The law enforcemen	t agency received a call at				
	4:40pm from the SIC/	Owner regarding Resident				
	#1 who had wandered	d off while shopping in an				
	adjacent county.					
		orted Resident #1 left the				
	store to go outside an					
	minutes.	had been missing for 45				
		rted Resident #1 lived in a				
	•	d be taken care of, and				
		medications for diabetes,				
	blood pressure, and s	schizophrenia.				
	-Numerous officers re	esponded to the scene but				
	were unable to locate	Resident #1.				
		m was completed, and the				
	state police were noti					
	-At 7:30pm, an officer verified Resident #1 h	went to the facility and				
	verillen Mesiderit #11	iau returneu nome.				
	Review of a second la	aw enforcement report dated				
	07/09/22 revealed:	·				
		t received a call at 7:30pm				
	regarding a female or					
	flagging down vehicle	es.				

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			_			
		FCL017018	B. WING		08/2	21/2023
NAME OF B	20//DED OD 01/DD1/ED	OTDEET ADI	DEGG OITY OTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	ROAD		
	,	BLANCH,	NC 27212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	LION	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRI	OPRIATE	DATE
				DEFICIENCY)		
C 243	Continued From page	50	C 243			
0 2 10	. •		02.0			
		told by the caller the female				
	said her great nephev	w was in danger of being				
	raped by someone sh	ne lived with.				
		t located the female and				
	identified her as Resi	dent #1.				
	-Resident #1 stated h	er mother brought her a				
		while she walked, and she				
		agon to arrive, and her great				
	nephew was in dange					
		he heard people talking				
		· · · · · · · · · · · · · · · · · · ·				
	about "it" while she w	, ,				
		d the address where she				
	lived.					
		Resident #1 to the facility.				
		the SIC/Owner who stated				
	Resident #1 was diag	nosed with schizophrenia				
	and had episodes wh	ere she thought her family				
	was in danger.					
	-The deputy informed	I the SIC/Owner of the				
	statements Resident					
		I she was the only one living				
	upstairs.	tene was are only one availy				
		ed Resident #1 heard voices				
	and the Administrator					
	enforcement agency	belore.				
	Review of a third law	enforcement report dated				
	03/06/23 revealed:	emoreement report dated				
	00/00/20 10/00/00	rom the SIC/Owner at				
		Resident #1 had walked off				
	from the facility.	11 (1 01010				
		ed from the SIC/Owner at				
	3:48pm revealed Res	sident #1 had returned to the				
	facility.					
	Review of a fourth law	w enforcement report dated				
	04/11/23 revealed:	w enforcement report dated				
		irom the SIC/Ours == =+				
		rom the SIC/Owner at				
	7:06pm who reported	Resident #1 had walked off				

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from the facility.

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		FCL017018	B. WING		00/	21/2023
		FCEUTTUTO			00/2	21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
TAVI OD 5	*******	1136 BER ⁻	THA WILSON R	ROAD		
IATLOR	AMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	OULD BE	COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPI DEFICIENCY)	ROPRIATE	DATE
				DEFICIENCY)		
C 243	Continued From page	e 60	C 243			
	-A second call receive	ed from the SIC/Owner at				
	7:08pm revealed Res	ident #1 had returned to the				
	facility.					
	-					
	Review of a fifth law 6 07/01/23 revealed:	enforcement report dated				
		rom the SIC/Owner at				
		d Resident #1 had walked				
	off from the facility.	u Nesidelit #1 Had Walked				
	-	ed from the SIC/Owner at				
		sident #1 had returned to				
	the facility.	oldone // Thad Total float to				
	aro raomy.					
	Review of a sixth law 08/18/23 revealed:	enforcement report dated				
	-The law enforcemen	t agency received a call at				
	12:24pm from the SIC had "walked off".	C/Owner that Resident #1				
		rted Resident #1 walked				
	•	oking for a lizard and had				
	been missing about o	-				
	-Resident #1 returned	to the facility on her own;				
	she stated she had go	one fishing.				
	-There was no time d	ocumented on the law				
	enforcement report of	f Resident #1's return.				
		acility on 08/18/23 between				
	8:00am and 10:06am	revealed:				
		e heard from Resident #1's				
	room; Resident #1 wa	as in her room alone.				
		he facility in her bedroom or				
	the living room.					
	Observe (Constitution of the constitution of t	VIO+ 40-50-				
		3/23 at 12:52pm revealed the				
		cility on the van to look for				
	Resident #1.					
	Observation on 00/40	1/22 at 1:15pm royaglad the				
	SIC/Owner returned t	3/23 at 1:15pm revealed the other than the facility without				

Division of Health Service Regulation

Resident #1.

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Division of	of Health Service Regu	ılation				
	COF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:			COMPL	
			_			
		FOI 047049	B. WING		00/5	24 (0000
		FCL017018			0012	21/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
TAVI OR F	AMILY CARE HOME #2	1136 BEF	RTHA WILSON RO	OAD		
IAILON.	AWILI CARL HOME #2	BLANCH	, NC 27212			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	KEGULATURT ON L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIAIE	DAIL
			+	<u> </u>		-
C 243	Continued From page	∍ 61	C 243			
	Interview with the SIC	C/Owner's family member on				
		revealed Resident #1 must				
	have walked to the m					
	Interviews with the SI	IC/Owner on 08/18/23 at				
	12:52pm, 2:16pm, an	ıd 2:43pm revealed:				
	-She left about 11:00a	am to go to the store to pick				
	up some items.					
		ident #1 when she left the				
	facility to go to the sto					
	· ·	the SIC/Owner's family				
		ident #1 had walked away				
	from the facility.					
		w long Resident #1 had				
	been gone from the fa					
	-She was going to loc					
	facility before and be	walked away from the				
	_	valk to the mailbox and				
	maybe a ½ mile to a					
		ident #1 up once when she				
	was about ½ mile dov	•				
		en gone before about 30				
	minutes but never this	•				
		valk to the mailbox daily at				
	2:00pm.	-				
		er walked off where she had				
	to call the law enforce					
		nforcement agency today,				
		0pm because Resident #1				
	had been gone for 2 t	to 3 hours.				
	l	20/40/20 1.0.00				
		ent on 08/18/23 at 2:26pm				
	revealed:	41 facility welling before				
		the facility walking before. be gone for "a while" and				
ļ	-Resident # i would b	e gone for a writte and				

then come back.

-The SIC/Owner had to go and pick Resident #1 up when Resident #1 did not come back home.

STATE FORM 6899 E4Y611 If continuation sheet 62 of 141

Division	of Haalth Camilaa Daaw	lation.			FORM APF	PROVED
STATEMENT	of Health Service Regul FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		FCL017018	B. WING		08/21/20	23
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR FAMILY CARE HOME #2		THA WILSON R NC 27212	COAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE CC	(X5) DMPLETE DATE
C 243	Continued From page	e 62	C 243			
	Resident #1 had walk Interview with Reside revealed: -She walked down the 08/18/23She was just walking anywhere specialShe did not go walking was not the first time the facilityShe came back hom Interview with a secon 8:24am revealed: -Resident #1 walked outingsResident #1 was see three males but they -The SIC/Owner was occurred, and the res lot waiting for the SIC -Resident #1 asked p were on outings, and -Resident #1 had left gone all day but never	pick Resident #1 up after ted away from the facility. Int #1 on 08/21/23 at 8:17am e street last Friday, g; she was not walking Ing "very often" but Friday she had walked away from e around 7:30 that evening. Ind resident on 08/21/23 at Ind resident on 08/21/23 at Indicate the parking lot. In a store when this idents were in the parking the facility before and was ar overnight.				
	2:28pm and 4:25pm r					

the facility.

days."

days a week.

up on the van "sometimes".

-Resident #1 would come back on her own "most

-The SIC/Owner had to go and pick Resident #1

-He did not think the local law enforment had picked Resident #1 up and brought her back to

STATE FORM 6899 E4Y611 If continuation sheet 63 of 141

DIVISION C	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			D 14//10	D. WING		
		FCL017018	B. WING		08/2	1/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE ZIP CODE		
TO TWIL OF TH	TO VIDER OR OUT FILER					
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	COAD		
		BLANCH,	NC 27212			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	(IATE	DATE
				22.18.2.18.17		
C 243	Continued From page	e 63	C 243			I
	9					I
						I
	Interview with the SIC	C/Owner on 08/18/23 at				I
	3:16pm revealed:					ı
	-Resident #1 liked to	panhandle when she went				ı
	on outings.					I
	-Resident #1 would g	ive strangers the facility's				ı
	address and phone n					I
	-Resident #1 would ta					I
	-Today Resident #1 w	vas talking about a little girl				I
		om and stole a lizard out of				I
	her pocketbook.					I
	-Resident #1 needed	the most supervision				I
		alk away from the facility.				I
	because sile would w	raik away ironi tile lacility.				1
	Telephone interview v	with the Administrator on				I
	-	evealed she had talked to				I
		r today, around 12:30pm but				I
						I
		ident #1 had walked away				I
	from the facility.					I
	-					1
	Telephone interview v					I
		e local Department of Social				I
	Services on 08/21/23	•				I
		her supervisor on Friday,				I
	· · · · · · · · · · · · · · · · · ·	1 had wandered from the				I
	facility.					I
	-The SIC/Owner did r	not notify DSS Resident #1				I
	had walked away fror	n the facility on 08/18/23.				ı
	-The SIC/Owner had	never notified DSS Resident				I
	#1 had wandered from	n the facility.				I
	-The SIC/Owner infor	med her on Friday,				I
	08/18/23, Resident #	1 had walked away when				ı
		on 06/23/22, and she had to				I
	wait 2 hours before R					
	= =	people for money when				
	Resident #1 was out	· · · · · · · · · · · · · · · · · · ·				
		cility on Saturday, 08/19/23				
					ļ	1
	at 10:10am; there wa	s one resident sitting outside	1			1

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the door.

-When she entered the facility living quarters

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/2	1/2023
TAYLOR FAMILY CARE HOME #2		DRESS, CITY, STA THA WILSON R NC 27212				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 243	roomThe SIC/Owner was with the door closed; sitting outside and fou Telephone interview v 08/18/23 at 5:00pm re-The SIC/Owner had #1 wandered from the The SIC/Owner woulfor the residents until put in placeSomeone would stay quarters, awake, to en Review of a voicemai Administrator on 08/1 Resident #1 had return resident was "ok." Observation of the fact 8:00am and 9:30am resident was "ok." Observation of the SIC 9:55am revealed she facility. Observation of the SIC 10:05am revealed she alone.	on her side of the house there was one resident ar residents in their rooms. with the Administrator on evealed: not informed her Resident ar acility. d provide 24/7 monitoring an alarm system could be in the residents' living ansure the residents' safety. I received from the 8/23 at 7:25pm revealed and to the facility and the cility on 08/21/23 between evealed Resident #1 was in oom or living room. C/Owner on 08/21/23 at got in the van and left the C/Owner on 08/21/23 at a returned to the facility s/Owner on 08/21/23 at go and pick up Resident #1 from the facility. ked to the end of the	C 243			

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-Resident #1 said she was going to get her

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		SURVEY PLETED	
		FCL017018	B. WING		08	/21/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR	FAMILY CARE HOME #2		THA WILSON R NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 243	pocketbookShe was headed bad said she was on Frida-Resident #1 was par and people stealing fi it." Interview with the SIC 2:12pm revealed: -Resident #1 went ou would take a few minutes, she would washe could see through the resident left the fatorous the resident #1 was on minutes, she would washe could see through the resident left the fatorous the resident #1 washere Resident #1 washere Resident #1 smoking shoes, she thought the went looking for her. Observation on 08/21-Resident #1 walked residents' living quart drivewayAt 1:53pm, the SIC/C walked out the exit do quarters and looked of turned and walked in calling for Resident #1-At 1:57pm, the SIC/C drove down the driver minutes.	ck to the pond where she ay, 08/18/23. Fanoid about her pocketbook rom her; "she even slept with choose of the even slept with	C 243			

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Division c	<u>of Health Service Regu</u>	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON RO	OAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 243	Continued From page	 ≥ 66	C 243		
	2:00pm revealed: -She drove down the #1 had walked to the -Resident #1 was wal when she saw herResident #1 told the to the mailboxShe reminded Resid to the mailbox alone. Interview with the SIC 08/21/23 at 2:10pm re -She saw Resident #' doorShe went to the door Resident #1Another resident was asked if he saw Resid walked in the opposit -She walked fast and	SIC/Owner she had walked ent #1 that she could not go C/Owner's family member on evealed: 1 walk out the living room r and looked but did not see s sitting outside and when dent #1, he stated she e direction of the driveway.			
	revealed: -She went to the mail -She did not tell anyo mailboxShe was walking bac the SIC/Owner came	·			
	the house.	s vall, sile walked back to			
		I/23 at 3:36pm revealed king on the driveway toward n her hand.			
	Interview with Reside	ent #1 on 08/21/23 at 3:42pm			

house).

-She walked to the mailbox (0.3 mile from the

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/2	1/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2	1136 BERT	HA WILSON R	OAD		
IAILORI	AMILI VARE HOME #2	BLANCH, N	IC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 243	Continued From page	e 67	C 243			
	living quarters.	ck door of the residents'				
	on 08/21/23 at 3:37pr -She thought Resident -She was in the resident living room; she did not past herShe must have doze walked past herShe would have hear gone out the back doorShe did not know Redoor. Observation of the Signature.	ents' living quarters in the ot see Resident #1 walk d off and Resident #1 rd Resident #1 if she had or. sident #1 went out the back				
	her chair so she could	n revealed she re-positioned d see both exit doors. with a nurse at Resident #1's				
	Primary Care Provide at 12:22pm revealed: -The PCP's office was walked away from the was gone for 9 hoursThere was no docume ever walked away from the PCP would have Resident #1 walked a -Resident #1 could have blood sugar because may not have been as	r's (PCP) office on 08/21/23 s not notified Resident #1 facility on 08/18/23 and fentation Resident #1 had m the facility. s wanted to know each time				
	schizophrenia so she disoriented and start l					

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Interviews with the SIC/Owner on 08/21/23 at

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
		501.047040	B. WING		00/6	1/0000
		FCL017018	B: Wiito		08/2	21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
		1136 BER	THA WILSON R	ROAD		
TAYLOR F	AMILY CARE HOME #2		NC 27212			
	CLIMMA DV CT	·		DROVIDEDIC DI ANI CE CODDECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
C 243	Continued From page	. 60	C 243			
C 243	Continued From page	9 08	0 243			
	10:32am, 2:12pm, 3:4	17pm revealed:				
	-She notified Residen	it #1's legal guardian who				
	was at a DSS in anot	her county on 08/18/23				
		1 walked away from the				
	facility.	,				
	•	call the local DSS to let them				
		d walked away from the				
	facility.	,				
	_	e was supposed to call the				
		sident was known to be				
	missing from the facil					
		valk to the mailbox daily.				
		#1 walked out the back door;				
	she heard the door or					
		lent #1 walk through the				
		way when she was in the				
	kitchen.	may interrested that it the				
		et the mail and come back				
	to the facility.					
	_	back door open or close				
		Resident #1 leave the facility				
	for the third time on 0					
		nad been staying in the				
		ne residents on third shift				
	since Friday, 08/18/23					
	• • • • • • • • • • • • • • • • • • • •	ft was being covered by				
	herself and her family					
	•	y the residents said they did				
		ember in the facility, because				
	"she was out there."	,				
		nily member may have				
		residence to ask a question,				
	and out of habit shut	•				
	-Her family member of					
		bathroom, wash up and				
	change clothes.	zz zom, maon ap ana				
		vas in the private residence				
	_	ready, but Resident #1 was				[
	in the bed asleep.	roddy, but reddedit #1 was				
		went back to bed after				
	-1 resident # 1 usually	שכווג שמטע נט שבט מונבו	1			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	,
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	'
			A. BOILDING.	A. BUILDING:		
		FCL017018	B. WING		08/21/202)2
					1 00/21/202	23
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	,		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R	COAD		
		BLANCH	, NC 27212	-		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		MPLETE DATE
1710		,	,,,,,	DEFICIENCY)		
C 243	Continued From page	e 69	C 243			
	would get washed up	s when her family member				
	-She would check on					
		nily member was not in the				
		ers, but once Resident #1				
	• .	ayed in the facility all the				
	time.	,				
	-Resident #1 was slic	k and had slipped by even				
		mber was in the facility				
	providing supervision					
		because it was dangerous				
		lk away and something				
	could happen to her.					
		olice before when Resident				
		ore the police even got there				
		rned so she did not do an				
	incident report.	ked off "8-9 times this year"				
		only time she could not find				
	the resident.	only and one could not ma				
	-Resident #1 would u	sually be back within an				
	hour.	•				
	Interviews with the Ac	lministrator on 08/21/23 at				
	11:39am, 3:48pm and	•				
		sident #1 was walking away				
	and leaving the facility	•				
		sident #1 had walked away				
	from the facility today					
		to keep someone in the ers to watch Resident #1.				
	• .	d outside someone would				
	have to go outside wi					
	•	#1 would walk to the mailbox				
		#1 always returned to the				
	facility.					
	-	sident #1 had walked to the				
	mailbox and continue	d down the road and the				
	SIC/Owner had to go	pick Resident #1 up in the				
	van on 08/18/23 and	08/21/23.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
TAVI OD F	AMILY CARE HOME #0	1136 BER1	THA WILSON R	OAD	
TAYLOR FAMILY CARE HOME #2 BLANCI			NC 27212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 243	Continued From page	e 70	C 243		
	Resident #1 each tim -The facility staff need the residents to ensurand go to the road. Attempted interview v	ded to go outside with e she went outside. ded to pay more attention to re they did not walk away with Resident #1's Mental 8/21/23 at 10:17am was			
	guardian on 08/21/23 unsuccessful.Refer to resident on 08/21/23	the interview with a			
	Refer to the interview 08/21/23 at 3:48pm a 2. Review of Residen 11/07/22 revealed dia	s with the Administrator on nd 4:47pm. t #5's current FL-2 dated ignoses included dementia sturbance, hypertension, and			
		5's Resident Register had a legal guardian.			
		was adjudicated county Department of Social approved guardian for			
	Review of Resident # 11/07/22 revealed: -Resident #5 was sor -Resident #5 had sigr must be directed.				

Division of Health Service Regulation

STATE FORM 6899 E4Y611 If continuation sheet 71 of 141

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A RUIL DING COMPLETI	ED I
A. BUILDING:	
FCL017018 B. WING 08/21/	/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
TAYLOR FAMILY CARE HOME #2 1136 BERTHA WILSON ROAD BLANCH, NC 27212	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 243 a. Review of the facility's resident contract revealed: -The policy on abusive language included using abusive language would not be permitted and frequent continued use of such language would mean the resident was unable to adjust to the home rules regarding respect for the rights of others. -The touching of another resident without their consent for the purpose of harassment, abuse, or exploitation would not be permitted. Interview with a resident on 08/18/23 at 11:34am revealed: -Resident #5 had hit him twice, once while he was in the living room and once when he was in the laundry room. -The SIC/Owner was not in the facility but was in her private residence separated by a door and the door was always closed. -He told the SIC/Owner Resident #5 had hit him and the SIC/Owner tell Resident #5 not to hit other residents. -The SIC/Owner did the same thing when Resident #5 hit him a second time. -He did not recall when the altercations were, but he had only lived at the facility since the fall of 2022. -He had heard Resident #5 argue with other residents but did not know if Resident #5 had hit any other residents. Interview with a second resident on 08/21/23 at 9:19am revealed: -Resident #5 "got on her nerves." -Resident #5" got on her nerves."	

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING	B. WING		1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAVI OR F	AMILY CARE HOME #2	1136 BER	THA WILSON R	ROAD		
IAILORI	AMILI GARLITOME #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 243	Continued From page 72		C 243			
	-She knew the SIC/Owner did not do anything about Resident #5 arguing/hitting because Resident #5 was still arguing with her.					
	Interview with Reside 11:49am revealed:					
	-She had never hit ar-She and her roomma					
		t she had never hit another				
	Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -Resident #5 had a diagnosis of dementiaShe could tell Resident #5 something and two minutes later the resident would not rememberResident #5 "tended to hit others." -When she talked to Resident #5 about hitting other residents, Resident #5 denied hitting anyoneShe had not witnessed Resident #5 argue or hit other residents; she was only told that it occurredShe did not recall when the incidents occurred. Telephone interview with Resident #5's legal guardian on 08/21/23 at 8:45am revealed: -Resident #5 had a diagnosis of dementiaShe expected the facility staff to provide					
	Telephone interview of 08/21/23 at 4:43pm resident. -She was not aware for residentShe would have expended.	Resident #5 had hit another ected the SIC/Owner to let d have talked to Resident #5				

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-She would not want a resident to get hurt.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
TAVI OD I	TABAULY CADE LIONE #0	1136 BEI	RTHA WILSON RO	AD		
IAYLOR	FAMILY CARE HOME #2	BLANCH	I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 243	C 243 Continued From page 73		C 243			
		interview with Resident #5's Provider on 08/21/23 at essful.				
	Refer to the interview with a resident on 08/21/23 at 9:35am.					
	Refer to the interview with the SIC/Owner on 08/18/23 at 2:12pm.					
	Refer to the interviews with the Administrator on 08/21/23 at 3:48pm and 4:47pm.					
	b. Review of the facility's resident contract revealed: -House rules included staff would supervise residents who smokedSmoking indoors was prohibited. Any indoor smoking would show the resident was unable to adjust to the home rules regarding respect for the rights of others the facility reserved the right to request the resident, family, or responsible person, make other placement immediately, when it is believed that a delay would jeopardize the resident's or others health and safetyThe facility staff reserved the right to confiscate all smoking materials if the resident failed to abide by the smoking policies to ensure fire safety for themselves and or other residents.					
	-Resident #5 went in smoke. -There was no staff p Resident #5 went in a -Multiple times Resident for their ciga	00am-3:00pm revealed: and out of the facility to resent in the facility when				

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Division c	Division of Health Service Regulation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
ANDILANC	N GORREGHON	IDENTIFICATION NOMBER.	A. BUILDING: _		COIVII EE	.160
		FCL017018	B. WING		08/2	1/2023
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R	OAD		
IAILORI	AMILI GARLITOME #2	BLANCH,	, NC 27212			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 243	Continued From page		C 243			
	outside.					
	08/18/23 at 3:25pm re-Resident #5 and and the residents' living re-Resident #5 walked the closed door connequarters to the SIC/O-Resident #5 knocked a cigarette from the SIC/Owner proving arette and closed thouse. -Resident #5 walked thouseResident #5 walked thouseResident #5 walked thouseResident #5 walked thouseResident #5 walked thouse.	other resident were seated in com. through the kitchenette to ecting the residents' living wner's house. d on the door and requested SIC/Owner. rided Resident #5 with a the door to the SIC//Owner's back to the living room and nt for a light.				
	08/18/23 at 4:45pm re- Resident #5 was in the cigarette in her hand. Resident #5 approach living room and asked	he living room with a				
	the living room.	ook his lighter and lit te while Resident #5 stood in outside once her cigarette				
	Interview with the SIC	C/Owner on 08/18/23 at				

-Resident #5 was not allowed to have a cigarette lighter because she and another resident had been lighting cigarettes inside the facility.

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DIVISION	n nealth Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		FCL017018	B. WING		08/21/2023
			1		1 00/2 1/2020
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TAYLOR F	AMILY CARE HOME #2	1136 BER	THA WILSON R	OAD	
1711 2011 1	721	BLANCH,	NC 27212		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1000
C 243	Continued From page	e 75	C 243		
	-She did not know Re	sident #5 had lit cigarettes			
	multiple times inside t	the facility, today, 08/18/23.			
	Intervious with Decide	nt #E on 09/21/22 of			
	Interview with Reside 12:20pm revealed:	111 #5 011 06/2 1/23 at			
	•	y she did not have a lighter.			
	-She thought she lost				
	-She had never smok				
	-She borrowed a lighter from another resident to light her cigarette and went "straight outside."				
	Telephone interview v	with the Administrator on			
		evealed she expected any			
	•	osis of dementia to be			
	supervised, and watc	hed more closely, for the			
	resident's safety.				
	Attempted telephone	interview with Resident #5's			
		Provider on 08/21/23 at			
	10:05am was unsucc	essful.			
	Refer to the interview	with a resident on 08/21/23			
	at 9:35am.				
	Refer to the interview	with the SIC/Owner on			
	08/18/23 at 2:12pm.	with the Glo/Owner on			
	00/10/20 dt 2:12pm:				
	Refer to the interview	s with the Administrator on			
	08/21/23 at 3:48pm a	nd 4:47pm.			
	Interview with a reside	ent on 08/21/23 at 9:35am			
	revealed:				
		nily member stayed in the			
	facility on 08/19/23 bunight.	ut did not stay any other			
		n the facility on Friday,			
		08/20/23, but the residents.			
	Interview with anothe	r resident on 08/21/23 at			

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2:00pm revealed on 08/21/23 sometime between

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING		08/21/2023	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 00/21/	
			HA WILSON R	·		
TAYLOR F	FAMILY CARE HOME #2	BLANCH, N	IC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 243	Continued From page 76		C 243			
	12:00am-2:00am, the resident went down the hallway and looked in the living room and there were two residents in the room, but no staff member.					
	2:12pm revealed: -She was not in the fa -She was in the facilit afternoon to clean.	y for about an hour each acility every morning to wake reakfast.				
	Interview with the Administrator on 08/21/23 at 3:48pm and 4:47pm revealed: -She had left a voicemail for the security system company that provided security and video for her facility to call her about this facilityShe thought staff was going to be in the resident area of the facility 24/7 or close byThe staff member could be in the private residence as long as the door was open to the facility and the staff could periodically check on the residentsResidents were expected to be supervised closer to ensure they were in the facility.					
	residents resulted in a of mental illness and unsupervised on 08/2 and on 08/21/23 for 3 were unknown each t who had a diagnosis sometimes disoriente and was not allowed she had a history of li	provide supervision for two a resident, who had a history diabetes, leaving the facility 18/23 for more than 9 hours times and her whereabouts ime (#1); and a resident, of dementia and was d, had hit other residents to have a lighter because ghting cigarettes inside the wed lighting cigarettes inside				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
		FCL017018	B. WING		08	3/21/2023	
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BE	T ADDRESS, CITY, STATE, ZIP CODE BERTHA WILSON ROAD CH, NC 27212				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
C 243	the facility while no st	aff was present (#5). This ious neglect of the residents	C 243				
	The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 08/18/23.						
		A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023.					
C 246	, , ,		C 246				
	This Rule is not met TYPE B VIOLATION	as evidenced by:					
	reviews, the facility fa	ns, interviews, and record illed to refer 1 of 3 sampled as a diabetic and needed I, to a podiatrist.					
	The findings are:						
	05/19/23 revealed dia	r type, schizoaffective					
	(PCP) after-visit sumi	had diagnoses including					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		FCL017018	B. WING	B. WING		
NAME OF B	ROVIDER OR SUPPLIER		DDDESS CITY STATE	710 0005	1 00	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER		.DDRESS, CITY, STATE RTHA WILSON RO			
TAYLOR I	FAMILY CARE HOME #2		I, NC 27212	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 246	Continued From page	e 78	C 246			
	been cutHis toenails were so end of his sock. Observation of Resid at 11:59am revealed: -Resident #2's first to protruded through the -All the cuticles arour and left feet were dry -The first toenail on h past the end of the to -The second toenail of the end of the toe and -The toenails on the toenails on the tend of the toenails on the left and right feet toesThe first toenail on h jaggedThe second toenail on h jagged.	to be cut. last time his toenails had long they had cut open the ent #2's toenails on 08/18/23 enail on his right foot e end of his sock. and the toenails on the right and cracked. is right foot was extended e by one-eighth of an inch. on his right foot curled over d was broken and jagged. hird, fourth, and fifth toes of curled over the end of the is left foot was broken and on his left foot extended the end of the toe and was rest toe. with Resident #2's PCP's 2:50pm revealed: eed to see a podiatrist for				
		rican Diabetic Association mmed because long or thick				

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DIVISION C	of Health Service Regu	liation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF D	ROVIDER OR SUPPLIER	etpeet Al	DDRESS, CITY, STA	TE ZID CODE	•	
NAME OF PI	ROVIDER OR SUPPLIER		RTHA WILSON R	,		
TAYLOR F	TAYLOR FAMILY CARE HOME #2			COAD		
			, NC 27212			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
C 246	Continued From page	÷ 79	C 246			
	. •					
		neighboring toes and cause				
	•	should be cut straight ng into the corners of a nail				
		toenails. An emery board				
		down any sharp edges.				
	Should be used to file	down any snarp edges.				
	Interview with the Sup	pervisor in Charge				
	-	1/23 at 2:12pm revealed:				
	-She could not cut Resident #2's toenails					
	because he was a dia	abetic.				
	-She had not seen Re	esident #2's toenails				
	because he was usua	ally always dressed.				
	-She had not asked F	Resident #2 if his toenails				
		sked to see his toenails.				
		appointment for Resident #2				
	to see a podiatrist.					
	Telephone interview v	with the Administrator on				
	08/21/23 at 4:43pm re					
	-She had not seen Re					
	-She did not know Re	esident #2's toenails needed				
	to be trimmed.					
	-Resident #2 needed	to be seen by a Podiatrist.				
	-She expected the SI					
	appointment for Resid	dent #2 to be seen by a				
	Podiatrist.					
		ails were not kept trimmed				
		perience an ingrown toenail				
	and get an infection.					
	The facility failed to a	 nsure a resident, who had				
		his toenails trimmed, was				
		st, which resulted in the				
	-	jagged toenails (#2) which				
		creased risk of injury. This				
	•	al to the health, safety and				
		nt, and constitutes a Type B				
	Violation.	·				
	A SUMMARY SUSPE	ENSION OF LICENSE WAS				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL017018	B. WING		08	/21/2023
	ROVIDER OR SUPPLIER	1136 BE	DDRESS, CITY, STAT RTHA WILSON RO I, NC 27212	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 246	Continued From page ISSUED ON AUGUST A Plan of Protection v	Г 23, 2023.	C 246			
C 249	following in the reside (3) written procedure a physician or other li and (4) implementation or	2 Health Care assure documentation of the	C 249			
	This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 2 of 3 sampled residents (#1, #2) related to fingerstick blood sugar monitoring for a resident who had a diagnosis of diabetes (#1); and blood pressure checks for a resident who had a diagnosis of hypertension (#2). The findings are: 1. Review of Resident #2's current FL-2 dated 05/19/23 revealed: -Diagnoses included schizoaffective bipolar type, schizoaffective personality disorder, and anxiety disorderThere was an order to check the resident's blood					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL017018	B. WING	B. WING		3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
TAYLOR F	FAMILY CARE HOME #2		THA WILSON R	OAD		
	7.11.12.1.0.11.2.1.2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 249	C 249 Continued From page 81		C 249			
	Review of Resident #2's Primary Care Provider's (PCP) after-visit summary dated 08/03/23 revealed Resident #2 had diagnoses including hyperlipidemia, diabetes mellitus, and hypertension.					
	2023, and August 202 revealed the only doc	s (MAR) for June 2023, July 23 from 08/01/23-08/21/23 umentation for a BP for 8/20/23 with a reading of				
	Review of emergency medical services (EMS) reports for Resident #2 revealed: -On 07/05/23, Resident #2's BP was documented as 162/120 at 2:57amOn 07/14/23, Resident #2's BP was documented as 132/80 at 9:02amOn 07/16/23, Resident #2's BP was documented as 126/67 at 5:17pm and 101/72 at 5:33pmOn 08/20/23. Resident #2's BP was documented as 157/99 at 10:34am and 142/90 at 10:47am.					
	nurse on 08/21/23 at -Resident #2 had a di -Resident #2 was taki for elevated BP and v dropping too lowIt was important to m	agnosis of hypertension. ing two different medications				
	revealed: -No one at the facility -He did not know if ar check his BP or not.	nt #2 on 08/18/23 at 4:20pm had checked his BP. hyone at the facility should lightheaded, but he did not				

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Division of	of Health Service Regu	ılation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		FCL017018	B. WING		08/2	1/2023
				_	1 00:2	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	OAD		
.,	72	BLANCH,	NC 27212			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
IAG		200 IDENTIFY THIS IN STANDARD	IAG	DEFICIENCY)	W// _	
2.2.12			+	<u> </u>		
C 249	Continued From page	e 82	C 249	Í		
				ĺ		
	Observation of Resid	lent #2's blood pressure on		İ		
	08/21/23 at 5:28pm re			İ		
		harge (SIC)/Owner took				
	Resident #3's BP.	•		İ		
	-His BP reading was	137/93.				
				Í		
		C/Owner on 08/21/23 at		İ		
	5:28pm revealed:			Í		
		mily member had taken		Í		
	Resident #2's BP rec	ently; she could not				
	remember the day.			Í		
		as not checked this morning.				
	-She was checking R			Í		
	because the surveyor	r asked ner too.				
	Interview with the SIC	C/Owner on 08/21/23 at				
	2:12pm revealed:	5/OWNER 011 00/2 1/20 at		Í		
		esident #2 had an order to		Í		
	check his BP.	701d01.1.				
	-After she was asked	I if any of the residents had		Í		
		eir BPs on 08/18/23, she		Í		
	looked at the residen	ts' records and saw				
	Resident #2 had an o	order for BP checks, but the		Í		
	order did not say how	v often.		Í		
	-She did not recall wh	hat Resident #2's BP order		Í		
	was.			İ		
	_	sident #2's FL-2, she stated		Í		
	she did not see the B			Í		
		Resident #2's BP was shown		Í		
		order as B10 and PRE.		Í		
		it was ordered as BID (twice				
		needed) she stated "Yes, I		Í		
	· ·	Resident #2's BP was		İ		
	supposed to be check			Í		
	1	member check Resident #2's /23, in the morning but				
		s not checked a second		Í		
ļ	, Nesideni #2 s Dr Wa:	S HOL CHECKEU A SECONU				

time.

-She did not know Resident #2 had an order to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO	AD		
	T		I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 249	Continued From page	e 83	C 249			
C 249	check his BP until 08, overlooked it." -She forgot to check I Saturday, 08/19/23, a hospital on Sunday, 0 checked his BP once -Resident #2 returned 08/20/23, "a little after Telephone interview v 08/21/23 at 4:43pm re-She expected the Sliso she would know w-She expected the Sli#2's BP twice daily as the results. 2. Review of Resident #1/29/22 revealed a comellitus type 2. Review of Resident #06/27/23 revealed the fingerstick blood sugaweek or if the residen Review of Resident #administration record 06/30/23, July 2023 M from 08/01/23 to 08/1 entry for FSBS check Observation of the Su (SIC)/Owner during the medication pass on 0-The SIC gathered sugarners and sugarners are sugarners.	Resident #2's BP on and Resident #2's BP on and Resident #2 went to the 08/20/23, so she only of from the hospital on a 3:00pm." With the Administrator on evealed: C/Owner to review the FL-2 that to do for Resident #2. C/Owner to check Resident a ordered and to document or a thick that the sorter of the sort	C 249			
	medication pass on 0 -The SIC gathered su -The SIC checked Re	8/21/23 revealed: applies for a FSBS check. esident #1's FSBS with a				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
TAVI OD 5	*******	1136 BER	THA WILSON R	OAD	
IAYLOR	AMILY CARE HOME #2	BLANCH,	NC 27212		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 249	Continued From page	e 84	C 249		
	revealed: -There was 1 FSBS reading of 134 on 08/21/23 at 8:48pmThere next five FSBS readings were from April 2023. Interview with Resident #1 on 08/21/23 at 8:17am revealed: -She could not recall the last time her FSBS was checked before this morningShe did not know her FSBS was to be checked weekly. Telephone interview with a nurse at the Primary Care Provider's (PCP) office on 08/21/23 at 12:22pm revealed: -There was an order written on 06/27/23 for Resident #1 to have weekly FSBS checksResident #1's last hemoglobin A1C (hgb A1C) was 6.7 on 02/27/23. (The hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7.)				
	8:43am revealed: -There was an order of FSBS reading weekly -She had checked Retimes since it was ord -She used the same of checkShe did not know who was and July 2023 who were a few weekly	esident #1's FSBS 5 to 6 lered in June 2023. glucometer with each FSBS by the readings from June were not in the glucometer. beks she did not check because Resident #1 would			
	Telephone interview v	vith the Administrator on			

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08/21/23 at 4:41pm revealed:

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		F01.047046	B. WING		00/04/2222
		FCL017018	B. WING		08/21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	OAD	
		BLANCH,	NC 27212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
C 249	Continued From page 85		C 249		
	pharmacy so it could -The SIC/Owner show reading each time it v -If the SIC/Owner did FSBS reading, she st why it was not checket	not check Resident #1's nould document a reason			
	The facility failed to implement orders for blood pressure checks twice daily and as needed for a resident, who had a diagnosis of high blood pressure, was treated with two medications to lower the blood pressure, and had experienced feeling lightheaded (#2); and for a weekly fingerstick blood sugar check for a resident, who had a diagnosis of diabetes (#1). The failure of the facility to implement orders was detrimental to the health and safety of the residents, and constitutes a Type B Violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023.				
	A Plan of Protection v	vas not obtained.			
C 254	10A NCAC 13G .0903 Professional Support	. ,	C 254		
	registered nurse, occ respiratory care pract in the on-site review a residents' health statu provided, as required	assure that participation by a upational therapist, itioner, or physical therapist			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2	1136 BERT BLANCH, I	THA WILSON R NC 27212	ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 254	(1) performing a phy resident as related to current condition requtasks specified in Par (2) evaluating the rebeing provided; (3) recommending cresident as needed by assessment and eval resident; and (4) documenting the (1) through (3) of this This Rule is not met Based on observation interviews, the facility Health Professional S was completed within resident developed the 3 sampled residents (fingerstick blood sugation of the findings are: Review of Resident # 11/29/22 revealed a comellitus type 2. Review of Resident # 06/27/23 revealed the fingerstick blood sugative week or if the resider	in the date a resident in the task and at least and includes the following: resical assessment of the the resident's diagnosis or uliring one or more of the agraph (a) of this Rule; sident's progress to care thanges in the care of the assed on the physical uation of the progress of the activities in Subparagraphs Paragraph. as evidenced by: as evidenced by: as, record reviews, and failed to ensure a Licensed support (LHPS) evaluation and days from the date a see need for the task for 1 of (#1) with a LHPS task of ar (FSBS) monitoring.	C 254	DEFICIENCY		
	was no LHPS assess	ment completed since an order for weekly FSBS				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	(OVIDER ON OOF FEIER		THA WILSON R			
	FAMILY CARE HOME #2	BLANCH,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 254	Continued From page	e 87	C 254			
	checks on 06/27/23.					
	8:48pm.	ent #1's glucometer reading of 134 on 08/21/23 at S readings were from April				
	revealed: -She could not recall checked before this n	ent #1 on 08/21/23 at 8:17am the last time her FSBS was norning. er FSBS was to be checked				
	-She did not have any assessmentsShe thought the Pha assessmentsShe did not know the assessmentsShe did not know Re	1/23 at 2:31pm revealed: yone to do LHPS rmacist did the LHPS e requirements for LHPS esident #1 needed to have t with 30 days of the FSBS				
	4:41pm revealed: -She did not know whassessmentsShe thought the pharassessmentsThe LHPS assessments and days of a task beir -The SIC/Owner and	ents should be done within ng ordered. the Administrator were ing the LHPS assessment				

-She did not audit residents' records.

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		FOI 047040	B. WING			0/04/0000
		FCL017018	B. W0		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO	AD		
	_	BLANCH	I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 270	Service 10A NCAC 13G .0904 Menus in Family Care (7) The facility shall h diet menu for any resi	4 (c)(7) Nutrition And Food 4 Nutrition And Food Service 5 Homes: ave a matching therapeutic ident's physician-ordered uidance of food service staff.	C 270			
	facility failed to ensure diets were planned ar	and record reviews, the e menus for therapeutic nd/or reviewed by a licensed mpled residents (#2) who				
	The indings are.					
	05/19/23 revealed: -Diagnoses included schizoaffective persondisorder.	2's current FL-2 dated schizoaffective bipolar type, nality disorder, and anxiety er for HHCC (there was no nis diet was).				
	(PCP) after-visit summerevealed: -Resident #2 also had hyperlipidemia, diabe hypertensionThere was document	d diagnoses to include tes mellitus, and tation the PCP talked with importance of controlling				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE	,	
		1136 BER	THA WILSON R	OAD		
IATLOR F	FAMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 270	Continued From page	÷ 89	C 270			
		ugars, saturated fats, deep foods, with overall caloric				
		pervisor in Charge 8/23 at 4:08pm revealed all urrent diet order for a regular				
	-There were menus for salt diet, a no-concen low fat/low cholestero	signed by a Registered				
	revealed:	ent #2 on 08/18/23 at 2:37pm				
	not, but he tried to ea -All the residents were -He got a different cel other meals were the	t healthy. e served the same meal. real in the morning, but same. the facility because the				
	nurse on 08/21/23 at not sure what diet had #2, but the PCP had	with Resident #2's PCP's 2:50pm revealed she was d been ordered for Resident documented talking to e importance of nutrition.				
	2:12pm revealed: -Resident #2's FL-2 h	C/Owner on 08/21/23 at had his diet listed as regular. hat HHCC stood for that was 's FI -2.				

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-She had not seen HHCC listed on Resident #2's

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			SURVEY PLETED	
		FCL017018	B. WING		08	/21/2023
	ROVIDER OR SUPPLIER SAMILY CARE HOME #2	1136 BE	ADDRESS, CITY, STATE RTHA WILSON RO 1, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 270	-She did not have a narrhe Administrator has for the facility. Telephone interview would be did not know what is a side of the SIC/Owner shour resident's PCP to askalf the SIC/Owner did ordered by the PCP, stold the PCP what die one of the diets offered.	ular was listed as the diet. nenu for HHCC. d provided her with menus with the Administrator on evealed: at an HHCC diet was. uld have contacted the	C 270			
C 272	Service 10A NCAC 13G .0904 Service (d) Food Requirement (2) Foods and bevera accordance with each or made available to a between each meal for day and shown on the	nts in Family Care Homes: ages shall be offered in a residents' prescribed diet all residents as snacks or a total of three snacks per e menu as snacks. as evidenced by: as, record reviews, and failed to offer snacks to the	C 272			

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DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			==================================			
		FCL017018	B. WING		08/2	21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, STA	ATE, ZIP CODE		
TAYLOR F	TAYLOR FAMILY CARE HOME #2			ROAD		
., .,,	,	BLANCH,	NC 27212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE API DEFICIENCY)	PROPRIATE	DATE
				DEFICIENCY)		
C 272	Continued From page	<u> </u>	C 272			
0	Continued i form page	201	0 = 1 =			
	Review of the facility's	s menu revealed snacks				
	were not listed on the menu.					
	Observation on 08/18	3/23 and 08/21/23 at various				
	times between 9:00ar	m and 5:00pm revealed				
		offered to the residents.				
	Observation of snack	s provided to the surveyor				
		Charge (SIC)/Owner on				
		evealed she had a box of				
	•					
	granola bars, fruit sna	acks, and popcom.				
	latamiaida a masid	t 00/40/02 -t 0:00m				
		ent on 08/18/23 at 2:26pm				
	revealed:					
		ck if she asked for one.				
	-She received a cook	ie yesterday.				
		r resident on 08/18/23 at				
	2:28pm revealed:					
		snacks today, 08/18/23.				
	-He received a snack	at night, between 8:00pm				
	and 9:00pm.					
	-The snacks were frui	it snacks, granola bars, or				
	popcorn.					
	-He did not receive a	snack in the morning or the				
	afternoon.	G				
	-Snacks were not ava	nilable during the day.				
	Interview with a third	resident on 08/18/23 at				
	2:36pm revealed:	2 2 3, 20 3.				
		nack when he asked for				
	one.	nack whom no dolled for				
		ilable were fruit snacks,				
	granola bars, or popo					
	•					
	-They had the same 3					
	-Snacks were not offe	ered three times a day.				
	Interview with a fourth	n resident on 08/18/23 at				

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2:37pm revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL017018	B. WING		08	8/21/2023
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BE	ADDRESS, CITY, STATE RTHA WILSON RO			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 272	-He sometimes got hilling and sometimes the SIC/Owner's door an -Sometimes the SIC/because she was bus back later. Interview with a fifth right going and sometimes the SIC/because she was bus back later. Interview with a fifth right going and sometimes with the SIC 3:12pm revealed: -Sometimes she forgures identsThe residents knock wanted a snackThe residents usuall day, but sometimes the per daySometimes she wou wanted a snack. Telephone interview of 08/21/23 at 4:43pm right going and sometimes per least three times per -The residents should	ungry during the day. The had to go to the discharge to the discharge to the discharge to the discharge to the discharge to the discharge to the put snacks out for the discharge to the discharg	C 272			
C 283	10A NCAC 13G .090 Service	4 (e)(3) Nutrition And Food	C 283			
	Therapeutic Diets in I (3) The facility shall n	naintain a current listing of an-ordered therapeutic diets				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COWII LETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STA	JE ZIP CODE	
	10115211 011 001 1 21211		RTHA WILSON R		
TAYLOR F	AMILY CARE HOME #2		, NC 27212		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 283	C 283 Continued From page 93		C 283		
	This Rule is not met	as evidenced by:			
		n, record reviews, and			
		failed to ensure a listing of			
		ian-ordered therapeutic diets			
		guidance of the facility staff sidents with an order for an			
	HHCC diet (#2).	sidents with an order for an			
	The findings are:				
		tchen during the initial tour			
		there was no diet listing of			
	residents with therape reference.	eutic diets available for			
	Review of Resident # 05/19/23 revealed:	⁴ 2's current FL-2 dated			
		-Diagnoses included schizoaffective bipolar type, schizoaffective personality disorder, and anxiety			
		ler for HHCC (there was no			
	explanation of what the	•			
		2's Primary Care Provider's			
	(PCP) after-visit sumi revealed:	mary dated 08/03/23			
	-Resident #2 also had	d diagnoses to include			
	hyperlipidemia, diabe	etes mellitus, and			
	hypertension.	tation the DCD talked with			
		tation the PCP talked with e importance of controlling			
	their lipid condition to				
	cardiovascular risk.				
	-The importance of di				
	restriction of simple s	ugars, saturated fats, deep			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL017018	B. WING		08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAV/ OD 5	· • • • • • • • • • • • • • • • • • • •	1136 BER	THA WILSON R	OAD		
IAYLOR F	AMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 283	Continued From page	94	C 283			
	fried or highly greasy foods, with overall caloric restrictions was discussed. Interview with the Supervisor in Charge (SIC)/Owner on 08/18/23 at 4:08pm revealed all the residents had a current diet order for a regular diet.					
	08/21/23 at 10:08am -She stayed with the SIC/Owner had an ov 07/30/23She did not have to p SIC/Owner had prepare	residents recently when the vernight hospital stay on prepare meals because the ared the meals before she turned to the facility before the next day.				
	3:12pm revealed: -She did not have a d for meal preparationNo other staff had pr	ew what to prepare so she				
	on 08/22/23 at 10:28a -She assisted the SIC neededShe cooked, administresidents on outings, of daily living (ADLs) -She worked at the fashe did not recall the -She worked an 8-horbreakfast and lunch of	c/Owner when she was stered medications, took and assisted with activities as needed. cility a couple of weeks ago;				

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day she worked.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				TE SURVEY MPLETED		
		FCL017018	B. WING		na na	/21/2023
NAME OF D			DDDESS SITV STATE	ZID OODE	1 00	72 172020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE RTHA WILSON RO			
TAYLOR F	AMILY CARE HOME #2		H, NC 27212	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 283	-She had not seen a resident who had dial -She probably used to the day she prepared Telephone interview of 04/21/23 at 4:43pm re-She expected the SI posted to use for measure -She was concerned preparing the resident	e served the same meal. diet list but thought a female betes was on a special diet. ess sodium and sweeteners I meals. with the Administrator on evealed: C/Owner to have a diet list als and snacks.	C 283			
C 284	Service 10A NCAC 13G .090-Service (e) Therapeutic Diets (4) All therapeutic die supplements and thic served as ordered by This Rule is not met Based on observation reviews, the facility fa supplement was services (#2) as order Provider (PCP) when 50% of their meal. The findings are:	ns, interviews, and record alled to ensure a nutritional	C 284			
	05/19/23 revealed: -Diagnoses included	2's current FL-2 dated schizoaffective bipolar type, nality disorder, and anxiety				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	-	
TAVI OD I	FAMILY CARE HOME #2	1136 BE	RTHA WILSON RO	AD		
IAILORI	AMILI CARL HOME #2	BLANCH	H, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 284	C 284 Continued From page 96		C 284			
	disorder.	for a [named] nutritional				
	supplement used for					
	supplement used for	people with diabetes.				
	Review of Resident #	2's Primary Care Provider's				
	(PCP) after-visit sum					
	revealed Resident #2	also had diagnoses to				
	include hyperlipidemia, diabetes mellitus, and					
	hypertension.					
	Observation of the breakfast meal service on 08/18/23 at 9:19am revealed:					
		ved two cups of whole grain				
	cereal with milk; he a					
		were served a different type				
	of cereal.					
	Observation of the ce	reele eveilable to the				
		at 9:21am revealed there				
	was one large box of					
	chocolate flavored pr					
	Interview with the Sup					
	did not have any of the	3/23 at 9:21am revealed she				
		ed it all today, 08/18/23.				
	because sile had use	a it all today, 00/10/20.				
	Interview with Reside revealed:	nt #2 on 08/18/23 at 2:37pm				
		ed more than one meal in a				
	day.	a more than one mean in a				
	•	ered or provided a nutritional				
	supplement when he					
	Observation of the br	eakfast meal service on				
	08/21/23 at 8:55am re					
		eating bowls of cereal.				
		nking a cup of coffee and				
	juice.	-				
		have any cereal or any other				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		00	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		THA WILSON RO NC 27212	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 284	Continued From page	e 97	C 284			
	food items.					
	revealed: -The facility did not hat eat today, 08/21/23He did not like the cawere eatingHe was not offered a breakfast.	ant #2 on 08/21/23 at 9:40am ave a cereal he wanted to ereal the other residents any other food items for				
	-Resident #2 always -She knew Resident is she would go into the finished eatingShe was not aware feat his meals unless what she had prepare -There were times wh what she had prepare did not have an alterr -She had offered Res to eat but he did not w -She did not recall wh to eat what she offere miss meals a lotShe did not know wh was, and she did not supplement to provide	at 2:12pm revealed: ate his meals. #2 ate his meals because facility before the residents Resident #2 did not always it was when he did not like ed. hen Resident #2 did not like ed for the dinner meal; she hate menu to choose from. hiddent #2 something different want what she offered. hen Resident #2 did not want ed but Resident #2 did not hat the [named] supplement have a nutritional e to Resident #2. brder for the nutritional				
		C/Owner on 08/21/23 at located a magnifying glass 2's FL-2.				
	Second interview with	the SIC/Owner on 08/21/23				

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at 3:12pm revealed:

STATE FORM 6899 E4Y611 If continuation sheet 98 of 141

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		FCL017018	B. WING		08	/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	OAD		
0/0.15	SHMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	PECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 284	Continued From page 98		C 284			
	have the nutritional stands and missed one meal or missed one meal or missed one meal or missed one meal or missed one meal or missed one meal or missed the supplement. Telephone interview of 08/21/23 at 4:43pm meal of 1/23 at 4:	er meant for Resident #2 to upplement if the resident nissed eating all day. with Resident #2's Primary P) nurse on 08/21/23 at esident #2 was not eating a recould drop, and he would for nutrition. with the Administrator on evealed: ment was a nutritional people with diabetes. esident #2 had an order for ment to be served if the a fifty percent. ected the SIC/Owner to dent #2's PCP to obtain a upplement so she could				
C 288	10A NCAC 13G .090	5(a) Activities Program	C 288			
	residents' active involute in their families, and the This Rule is not met Based on record reviews.	home shall develop a designed to promote the lyement with each other, community. as evidenced by: ews, observations, and failed to ensure activities				

Division of Health Service Regulation

STATE FORM 6899 E4Y611 If continuation sheet 99 of 141

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			23/25/110		
		FCL017018	B. WING		08/21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
TAYLOR F	AMILY CARE HOME #2	1136 BEF	RTHA WILSON R	OAD	
IAILORI	AMILI GARL HOME #2	BLANCH	, NC 27212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 288	Continued From page	99	C 288		
	involvement and engaresided in the facility.	aged the residents who			
	The findings are:				
	Review of the August revealed:	2023 activities calendar			
	-The calendar was lying on the dining room table in the Supervisor in Charge (SIC)/Owner's private				
	residence.				
	-There was one entry	per day. and worship was listed;			
	there was no start or				
		ning and wash day was			
	listed; there was no s	tart or stop time.			
		dollar store were listed;			
	there was no start or	stop time. I included, movie night, word			
		i to music, pizza party,			
		and checkers; there were no			
	start or stop times list	ed.			
		08/18/23 was movie night			
	and 08/21/23 was list times were listed).	ed as mall/dollar store (no			
		sidents on 08/18/23 and			
	revealed:	mes from 8:00am-5:00pm			
	 One resident only ca meals. 	me out of his room to eat			
		their rooms, in the living			
	room, or outside on the	ne porch. ties offered to the residents.			
	- mere were no activi	ues onereu to the residents.			
	Interview with a reside revealed:	ent on 08/18/23 at 8:10am			
		ties for the residents to do;			
	he slept, ate, and was -He went out with the	s bored. SIC/Owner and the other			

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residents 1 to 2 times a week.

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Division of	of Health Service Regu	ılation				
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED)
		FCL017018	B. WING		08/21/20	023
NAME OF P	ROVIDER OR SUPPLIER	STREET A'	DDRESS, CITY, STA	TE, ZIP CODE		
			RTHA WILSON R			
TAYLOR F	FAMILY CARE HOME #2		I, NC 27212			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		OMPLETE DATE
TAG		200 IDENTIL TINO IN CLASS CLOSE	TAG	DEFICIENCY)	NAIL	
C 288	Cantinuad From page	- 400	C 288			
C 288			C 200			
		ocery store and a few other				
	stores.					
	Interview with anothe	er resident on 08/21/23 at				
	9:19am revealed:	Trosident on oot 1,20 at				
	-The residents did no	ot have activities at the				
	facility.					
	-All she did was walk.					
	Interview with a third	resident on 08/21/23 at				
	8:24am revealed:	Tesident on 00/2 1/20 at				
		vities at the facility, "nothing				
	at all."	<i>y</i> . 3				
	-They never had grou					
	1	te in activities if they were				
	offered.					
	Interview with the SIC	C/Owner on 08/21/23 at				
	2:12pm revealed:	, -				
		ity "basically" were going on				
	outings three times pe					
	-She took the residen to lunch.	nts riding, shopping, and out				
		ot participate in games.				
		sed a resident she would				
		er, but she "never got to it."				
		the facility for the residents				
	to play if they wanted					
	-There were magazin residents to look at.	es available for the				
		cercise when they went out				
	the door.	orolog mion may have all				
		day was when the residents				
		ether, straightened their				
	closets and such."	Baka da a ang makinda.				
	-Praise and worship v	were listed as an activity				
		ad not; "she did not want to				
	push it on anyone."	ad not, one did not want to				

-A resident wanted to go to church but the other

STATE FORM 6899 E4Y611 If continuation sheet 101 of 141

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAN	DF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMILETED	
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TAVI OD E	AMILY CARE HOME #2	1136 BER	THA WILSON R	OAD		
IAILORI	AWILI CARE HOWE #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 288	Continued From page 101		C 288			
	residents did not want to so the resident could not go.					
	Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -She had seen the facility's activity calendar and told the SIC/Owner she was supposed to have times on the calendar and each week a total of 14 hours should be providedShe did not consider cleaning and wash day an activity; they probably could have worded that a different wayThe SIC/Owner could have listed things like going to the library or ridingShe had not asked the residents if they had been offered activitiesShe felt bad for the residents not having anything to do and had talked to the SIC/Owner about signing the residents up for a day program.					
C 301	10A NCAC 13G .0906 Services	6 (f)(1)-(4) Other Resident	C 301			
	(f) Visiting. (1) Visiting in the horeasonable hours sha arranged through the of the residents and a (2) There must be at visitation in the home community. If a home hours or any restriction about the hours and a included in the house at the time of admissi conspicuously in the limited of the house at the time of admissing conspicuously in the limited of the house at the time of admissing conspicuously in the limited of the house at the time of admissing conspicuously in the limited of the house at the time of admissing conspicuously in the limited of the house at the time of admissing conspicuously in the limited of the house at the time of admissing conspicuously in the limited of the house at the time of admissing conspicuously in the limited of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at the time of the house at th	mutual prior understanding administrator; t least 10 hours each day for by persons from the e has established visiting ons on visitation, information any restrictions must be rules given to each resident on and posted				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′		(X3) DATE SURVEY COMPLETED	
	FCL017018	B. WING		08	/21/2023
PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
FAMILY CARE HOME #2			AD		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
planned visiting and of which indicates the reexpected time of return telephone number of (4) If the whereabout and there is reason to safety, the person in immediately notify the person, the appropria	other scheduled absences esident's departure time, rn and the name and the responsible party; uts of a resident are unknown to be concerned about his charge in the home must be resident's responsible ate law enforcement agency	C 301			
Based on interviews a facility failed to imme of Social Services (D residents (#1), who h and wandered away and was gone more to	and record reviews, the diately notify the Department SS) for 1 of 1 sampled ad a history of mental illness from the facility on 08/18/23, han 8 hours and the facility				
11/29/22 revealed dia undifferentiated schiz type 2, hypothyroidist D deficiency. Review of Resident # revealed: -Resident #1 had a h -Resident #1 received illness.	agnoses included tophrenia, diabetes mellitus m, hypertension, and vitamin dated 11/29/22 istory of mental illness.				
	PROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page planned visiting and of which indicates the re expected time of return telephone number of (4) If the whereabout and there is reason to safety, the person in immediately notify the person, the appropriation and the county depart of Social Services (Diresidents (#1), who had wandered away and was gone more to did not know the wheeled to the service of Resident #11/29/22 revealed did undifferentiated schiztype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 3, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 2, hypothyroidistype 3, hypothyroidistype 3, hypothyroidistype 4, hypothyroidistype 4, hypothyroidistype 4, hypothyroidistype 5, hypothyroidistype 6, hypothyroidistype 6, hypothyroidistype 6, hypothyroidistype 6, hypothyroidistype 6, hypothyroidistype 6, hypothyroidistype 7, hypothyroidistype 8, hypothyroidistype 8, hypothyroidistype 9, hypothyroidist	FCLO17018 PROVIDER OR SUPPLIER STREET A 1136 BE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 102 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: Based on interviews and record reviews, the facility failed to immediately notify the Department of Social Services (DSS) for 1 of 1 sampled residents (#1), who had a history of mental illness and wandered away from the facility on 08/18/23, and was gone more than 8 hours and the facility did not know the whereabouts of the resident. The findings are: Review of Resident #1's current FL-2 dated 11/29/22 revealed diagnoses included undifferentiated schizophrenia, diabetes mellitus type 2, hypothyroidism, hypertension, and vitamin D deficiency. Review of Resident #1's care plan dated 11/29/22 revealed: -Resident #1 had a history of mental illnessResident #1 had a history of mental illness.	FCU017018 STREET ADDRESS, CITY, STATE TAMILY CARE HOME #2 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 102 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: Based on interviews and record reviews, the facility failed to immediately notify the Department of Social Services (DSS) for 1 of 1 sampled residents (#1), who had a history of mental illness and wandered away from the facility on 08/18/23, and was gone more than 8 hours and the facility did not know the whereabouts of the resident. The findings are: Review of Resident #1's current FL-2 dated 11/29/22 revealed diagnoses included undifferentiated schizophrenia, diabetes mellitus type 2, hypothyroidism, hypertension, and vitamin D deficiency. Review of Resident #1's care plan dated 11/29/22 revealed: -Resident #1 had a history of mental illnessResident #1 received medication for mental illness.	FCL017018 STREET ADDRESS, CITY, STATE, ZIP CODE 1136 BERTHA WILSON ROAD BLANCH, NC 27212 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 102 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 (DSS) for 1 of 1 sampled residents (#1), who had a history of mental illness and wandered away from the facility on 08/18/23, and was gone more than 8 hours and the facility did not know the whereabouts of the resident. The findings are: Review of Resident #1's current FL-2 dated 11/29/22 revealed diagnoses included undifferentiated schizophrenia, diabetes mellitus type 2, hypothyroidism, hypertension, and vitamin D deficiency. Review of Resident #1's care plan dated 11/29/22 revealed:	ROWIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1136 BERTHA WILSON ROAD BLANCH, NC 27212 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC BENTHYM REFORMATION) COntinued From page 102 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: Based on interviews and record reviews, the facility failed to immediately notify the Department of Social Services (DSS) for 1 of 1 sampled residents (#1), who had a history of mental illness and wandered away from the facility on 08/18/23, and was gone more than 8 hours and the facility did not know the whereabouts of the resident. The findings are: Review of Resident #1's current FL-2 dated 11/29/22 revealed diagnoses included undifferentiated schizophrenia, diabetes mellitus type 2, hypothyroidism, hypertension, and vitamin D deficiency. Review of Resident #1's care plan dated 11/29/22 revealed fire received medication for mental illness. -Resident #1 had a history of mental illnessResident #1 received medication for mental illness.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
		FCL017018	B. WING		08/21/2023	
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TAVLOD FA	MUV CARE HOME #2	1136 BERT	HA WILSON R	OAD		
IATLURFA	MILY CARE HOME #2	BLANCH, N	IC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 301	Continued From page 103		C 301			
	Review of a report fro agency dated 08/18/2 -The law enforcement 12:24pm from the Sup (SIC)/Owner that Restrained the mailbox look been missing about out time was 12:24pmResident #1 returned the stated she had go the stated she had go the enforcement report of the law in the Department of So 18/21/23 at 1:40pm restrained by the Department of So 18/21/23 at 1:40pm restrained by the law in the SIC/Owner did in the SIC/Owner did in the SIC/Owner informo 18/18/23, Resident #1 when shopping, and the law in the SIC 10:24am revealed: -She did not call the lost she did not know she DSSShe had called Residuals who worked at the nesche thought notifying	m a local law enforcement 3 revealed: t agency received a call at pervisor in Charge ident #1 had "walked off". Inted Resident #1 walked ooking for a lizard and had ne hour: last known secure I to the facility on her own; one fishing. Documented on the law Resident #1's return. It Home Specialist (AHS) at cial Services (DSS) on evealed: Deer supervisor on Friday, I had wandered from the International the facility on 08/18/23. Dever notified DSS Resident #1 Developed the facility. Developed the side of the				

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Interview with the Administrator on 08/21/23 at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR I	FAMILY CARE HOME #2		RTHA WILSON RO I, NC 27212	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 301	a resident walked aw -She expected the S DSS anytime there w -The SIC/Owner noti county because that legal guardian worke	uld notify the local DSS when vay and was missing. IC/Owner to notify the local vas a resident missing. fied the DSS in the adjoining was where Resident #1's	C 301			
C 311	all residents guaranted Declaration of Reside and may be exercised. This Rule is not met TYPE B VIOLATION. Based on interviews facility failed to prote being hit by another the residents were the respect related to resother. The findings are: 1. a. Review of Residents to the second of the sec	9 Resident Rights shall assure that the rights of seed under G.S. 131D-21, ents' Rights, are maintained d without hindrance. as evidenced by: and record reviews, the ct two residents (#1, #4) from resident and failed to ensure eated with dignity and sidents arguing with each dent #4's current FL-2 dated agnoses included mental ation-deficit/hyperactivity d intellectual developmental	C 311			
	Interview with Reside 11:34am revealed:	ent #4 on 08/18/23 at				

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DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
			D WING			
		FCL017018	B. WING		08/2	21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE. ZIP CODE		
			THA WILSON R			
TAYLOR F	AMILY CARE HOME #2	BLANCH,		COAD		
		BLANCH,	NC 2/212	T		т
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
TAG	NEGOLATORT OR I	100 IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	N/AI E	
						-
C 311	Continued From page	e 105	C 311			
	-A female resident ha	d hit him twice, once while				
	he was in the living ro	oom and once when he was				
	in the laundry room.					
		narge (SIC)/Owner was not				
		in her private residence				
	•	and the door was always				
	closed.	and the door was always				
		er the female resident had				
		wner said she would take				
	care of it.					
		vner tell the female resident				
	not to hit other reside					
		he same thing when the				
	female resident hit hir	-				
		nale resident argue with				
		d not know if the female				
	resident had hit any o	ther residents.				
	Interview with the fem	nale resident on 08/18/23 at				
		e had never hit another				
	resident.	e nad never nit another				
	residerit.					
	Defends the telenhou	- in-t-m-ii-th- th				
	Refer to the telephone					
	Administrator on 08/2	11/23 at 4:43pm.				
	h Daviou of Basidan	t #1's current FL-2 dated				
		ignoses included diabetes				
		ophrenia, hypothyroidism,				
	hypertension, and vita	amin D deficiency.				
		nt #1 on 08/21/23 at 9:19am				
	revealed:					
	 -A female resident go 					
		t her, but it had been a while				
	so she could not reca	ll any specific details.				
	1-4					
		nale resident on 08/18/23 at				
	11:49am revealed:					
	-She had never hit an	other resident.				

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-She and Resident #1 argued, and Resident #1

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL017018	B. WING		08	/21/2023
	ROVIDER OR SUPPLIER FAMILY CARE HOME #2	1136 BE	DDRESS, CITY, STATE			
		BLANCH	I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 311	Continued From page		C 311			
	-Resident #1 was ove -Resident #1's behavi -She had told the SIC	or upset her.				
	Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm.					
resident's 08/21/23 -The resident resident resident h -She wou Provider to need adjust Interview 3:00pm resident residen	resident's Mental Hea 08/21/23 at 10:05am -The resident had a d dementia without beh -The MH Provider had resident hitting others -She would expect the	revealed: iagnosis of unspecified avioral disturbances. d not been notified about the				
	3:00pm revealed: -A female resident "te -She had not witnessed other residents; she weighted to the she talked to the hitting other residents hitting anyone.	c/Owner on 08/18/23 at anded to hit others." ed the female resident hit was only told that it occurred. The female resident about the female resident denied the female resident denied the the incidents occurred.				
		with the Administrator on evealed she was not aware nother.				
	Refer to the telephone Administrator on 08/2					
	Interview with a res 11:34am revealed two always arguing.	sident on 08/18/23 at o female residents were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: C			
		FCL017018	B. WING		08	8/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO	AD		
0(0.15	CLIMMADV CT.	ATEMENT OF DEFICIENCIES	I, NC 27212	PROVIDER'S PLAN OF	CORRECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 311	C 311 Continued From page 107		C 311			
	Interview with a second resident on 08/18/23 at 11:49am revealed: -She and her roommate arguedHer roommate was overbearing and hatefulHer roommate's behavior upset her.					
	9:19am revealed: -Her roommate got or -Her roommate argue -She knew the SIC/O	d with others. wner did not do anything rguing because the resident				
	11:39am revealed: -Two residents and th	n resident on 08/21/23 at ne SIC/Owner argued. ng and fighting would stop.				
	3:00pm revealed: -She had heard argui and had to go into the residentsShe had had to raise beforeAnother resident told to the arguing; she die	c/Owner on 08/18/23 at ang in her private residence a facility to check on the a her voice at a resident I her he did not like listening and not recall when but the an at the facility since June				
	08/21/23 at 4:43pm re- -She was not aware re- -It was not fair to the elisten to the arguing a residents' nerves and and scared.	esidents were arguing. other residents to have to us it could get on the make the residents nervous				
	Refer to the telephone	e interview with the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		FCL017018	B. WING		08	/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON ROA H, NC 27212	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 311	Continued From page 108		C 311			
	Administrator on 08/2	21/23 at 4:43pm.				
	08/21/23 at 4:43pm responsibility to make safe and treated fairly	e sure the residents were /.				
	The facility failed to protect the rights of the residents related to two residents (#1, #4) being hit by another resident and the residents verbalizing they did not like listening to the arguing amongst the residents. The facility's failure to protect the residents' rights was detrimental to the health, safety, and welfare of the resident which constitutes a Type B Violation.					
	A SUMMARY SUSPE ISSUED ON AUGUS	ENSION OF LICENSE WAS T 23, 2023.				
	A Plan of Protection \	was not obtained.				
C 315	10A NCAC 13G .100	2(a) Medication Orders	C 315			
	the resident's physici for verification or clar medications and trea (1) if orders for admis resident are not date of admission or readr (2) if orders are not c (3) if multiple admission or readmission or readmission or readmis forms are not the san The facility shall ensu	ne shall ensure contact with an or prescribing practitioner ification of orders for tments: ssion or readmission of the d and signed within 24 hours mission to the facility; lear or complete; or on forms are received upon ssion and orders on the				

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STATE FORM 6899 E4Y611 If continuation sheet 109 of 141

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		FCL017018	B. WING		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2	1136 BEI	RTHA WILSON RO	AD		
.,	7.11.12.1 07.11.2 11.0 11.2 11.2	BLANCH	I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 315	Continued From page 109		C 315			
	facility failed to contact (PCP) for 2 of 3 samp	ews and interviews, the ct the Primary Care Provider coled residents (#1, #3) for for an anti-psychotic (#1)				
The findings are:						
	1. Review of Resident #1's current FL-2 dated 11/29/22 revealed: -Diagnoses included undifferentiated schizophrenia. -There was an order for clozapine 100mg (used to treat schizophrenia) at bedtime. Review of Resident #1's June 2023 medication administration record (MAR) revealed: -There was an entry for clozapine 100mg 6 tablets at bedtime with a scheduled administration time of 8:00pm. -There was documentation clozapine 100mg 6 tablets were administered at bedtime from 06/01/23 to 06/30/23.					
	-There was an entry f tablets at bedtime wit administration time of	f 8:00pm. tation clozapine 100mg 6 ered at bedtime from				
	08/01/23 to 08/17/23 -There was an entry f tablets at bedtime wit administration time of	or clozapine 100mg 6 h a scheduled				

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STATE FORM 6899 E4Y611 If continuation sheet 110 of 141

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			E SURVEY PLETED	
		FCI 047049	B. WING			0/04/0000
		FCL017018	B. Wiito		08	3/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO	AD		
	I		I, NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 315	Continued From page	e 110	C 315			
	tablets were administ 08/01/23 to 08/17/23.					
	Observation of medication on hand for Resident #1 on 08/18/23 at 10:24am revealed clozapine 100mg 6 tablets where in each 8:00pm multi-dose pack.					
	revealed: -She had been taking for a very long time; s of the medicationShe did not remembe medication to one tab	ont #1 on 08/21/23 at 8:24am 6 tablets of a medication whe did not know the name er the doctor changing the olet.				
	facility's contracted pl 11:40am revealed: -The pharmacy had a 6 tablets at bedtime of -The pharmacy received clozapine 100mg 6 ta 05/28/21. -The pharmacy did not clozapine 100mg at b -The pharmacy did not pharmacy did not pharmacy had dated 11/29/22, they see	narmacy on 08/18/23 at n order for clozapine 100mg lated 07/17/23. ved the original order for				
	Telephone interview voffice on 08/21/23 at -Resident #1 had an otablets at bedtimeThe FL-2 was compl PCP's office.	vith the nurse at the PCP's 12:22pm revealed: order for clozapine 100mg 6 eted by the staff at the as the correct medication				

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STATE FORM 6899 E4Y611 If continuation sheet 111 of 141

Division	of Health Service Regu	lation			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			5		
		FCL017018	B. WING		08/21/2023
NAME OF D	ROVIDER OR SUPPLIER	STREET AND	DRESS, CITY, STA	TE ZID CODE	
NAME OF FI	NOVIDER OR SUFFLIER				
TAYLOR F	AMILY CARE HOME #2	1136 BER	THA WILSON R	OAD	
		BLANCH,	NC 27212		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATIO		TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
			1	DEFICIENCY)	
C 315	Continued From page	. 111	C 315		
0 0 10	Continued From page	5 111	0 0 10		
	and strength but the i	ncorrect dosage was			
	entered on the FL-2.	3			
	Interview with the Sup	nervisor-in-Charge			
		1/23 at 10:10am revealed:			
	, ,				
		en clozapine 100mg 6			
	tablets for years.	- · · · · // // · · · · · · · · · ·			
		Resident #1's FL-2 she filed			
	the FL-2 in Resident				
		e Resident #1's FL-2 dated			
	11/29/22.				
	-She did not compare	the FL-2 dated 11/29/22			
	with the medications	on the MAR.			
	-She did not know the	e order on the current FL-2			
	was different from wh	at Resident #1 was being			
	administered.	9			
	-She did not give cop	ies of the FL-2 to the			
	pharmacy.				
	•	npared the FL-2 with the			
		PCP and pharmacy for			
	clarification.	CF and pharmacy for			
	ciarincation.				
	564444				
	Refer to the telephone				
	Administrator on 08/2	21/23 at 3:48pm.			
		t #3's current FL-2 dated			
	06/07/23 revealed:				
	-Diagnoses included I	bipolar, schizophrenia, and			
	post-traumatic stress disorderThere was no order for docusate sodium 100mg				
	(a stool softener) daily	•			
	,	•			
	Review of Resident #	3's hospital discharge			
		7/23 revealed there was an			
	order for docusate so				
	order for docusate so	didili 100mg daliy.			
	Davious of Davidson "	Olo Juno 2022 mandiardian			
		3's June 2023 medication			
	administration record	(MAR) from 06/08/23 to			

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06/30/23 revealed:

-There was an entry for docusate sodium 100mg

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	` '		
		FCL017018	B. WING		08/21/202	3
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	OAD		
		·	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COM	X5) PLETE ATE
C 315	Continued From page 112		C 315			
	8:00pm.	d administration time of tation docusate sodium was /08/23 to 06/30/23.				
	Review of Resident #3's July 2023 MAR revealed: -There was an entry for docusate sodium 100mg daily with a scheduled administration time of 8:00pm. -There was documentation docusate sodium was administered from 07/01/23 to 07/31/23. Review of Resident #3's August 2023 MAR from 08/01/23 to 08/17/23 revealed: -There was an entry for docusate sodium 100mg daily with a scheduled administration time of 8:00pm. -There was documentation docusate sodium was administered from 08/01/23 to 08/17/23. Observation of medications on hand for Resident #3 on 08/18/23 at 10:29am revealed there were docusate sodium 100mg capsules was in each 8:00pm multi-dose pack.					
	revealed: -He knew he had an o	order for a stool softener. softeners before he came to				
	facility's contracted pl 11:40am revealed: -The pharmacy had a 100mg daily dated 06 -The pharmacy receive from the hospital.	vith the Pharmacist at the narmacy on 08/18/23 at n order for docusate sodium 6/07/23. Ved the discharge summary of receive Resident #3's				

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STATE FORM 6899 E4Y611 If continuation sheet 113 of 141

DIVISION	or rieditii Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	.ETED
			1			
		FCL017018	B. WING		08/2	21/2023
NAME OF D		OTDEET AS	DDE00 01TV 0TA	TE 7/0 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	,		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R	ROAD		
		BLANCH,	NC 27212			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	'RIATE	DATE
				DEFICIENCY)		
C 315	Continued From page	113	C 315			
0010	Continued From page	2 110				
	-If the pharmacy had	received Resident #3's FL-2				
	dated 06/07/23, they	would have clarified whether				
		ontinue with docusate				
	** *	nue the medication since the				
		and the FL-2 was dated the				
	_	and the r L-2 was dated the				
	same date.					
	Interview with the Sup					
		1/23 at 10:10am revealed:				
	-Resident #3 had bee	en taking docusate sodium				
	since he was admitte	d to the facility.				
	-When she received f	Resident #3's FL-2, she filed				
	the FL-2 in Resident					
		nitted with a FL-2 and a				
	hospital discharge su					
		ge summary was taken to				
	the pharmacy.					
		the FL-2 dated 06/07/23				
	with the hospital discl	harge summary dated				
	06/07/23.					
	-She did not know do	cusate sodium was ordered				
	on the hospital discha	arge summary and not on				
	the FL-2.	3				
		npared the FL-2 with the				
		mmary and called the PCP				
		illinary and called the r Cr				
	for clarification.					
	A.,					
		interview with Resident #3's				
		er (PCP) on 08/21/22 at				
	10:05am was unsucc	essful.				
	Refer to the telephone interview with the					
	Administrator on 08/2	21/23 at 3:48pm.				
]
	Telephone interview v	with the Administrator on				[
	08/21/23 at 3:48pm re					
		uld compare the FL-2 with				
		new FL-2 was completed]
	and signed by the PC					
	-The SIC/Owner shou	uld make sure that the FL-2				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08	/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
TAYLOR F	FAMILY CARE HOME #2		RTHA WILSON RO H, NC 27212	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 315	and the MAR matche		C 315			
C 330	(a) A family care hor preparation and adm prescription and nonby staff are in accord (1) orders by a licens which are maintained (2) rules in this Section and procedures. This Rule is not met TYPE A2 VIOLATION Based on observation interviews, the facility medications as order residents (#1, #2, and anti-psychotic medication used to call a medication for elever the findings are:	4 Medication Administration ne shall assure that the inistration of medications, prescription and treatments ance with: ed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: Instructory record reviews, and refailed to administer ed for 3 of 3 sampled dd #3) including an	C 330			

Division of Health Service Regulation

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, , ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/21/2023		
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
TAVI OD I	FAMILY CARE HOME #2	1136 BER	THA WILSON R	OAD			
IAILORI	AWIET CARE HOWE #2	BLANCH,	NC 27212				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE	
C 330	Continued From page	e 115	C 330				
	antipsychotic medical schizophrenia) daily.						
	Review of Resident #1's signed physician's order dated 03/27/23 revealed there was an order to discontinue escitalopram 10mg. Review of the manufacturer's medication package insert revealed: -Escitalopram was a selective serotonin reuptake inhibitor (SSRI)Serotonin syndrome (a potentially fatal drug-induced condition cause by too much serotonin in synapses in the brain) has been reported with SSRIs including escitalopram when taken alone and when co-administered with buspirone and lithium also medications Resident #1's was receivingSymptoms of serotonin syndrome included mental status changes, hallucinations, anxiety, and delirium. Review of Resident #1's June 2023 medication administration record (MAR) revealed:						
	of 8:00am.	tation escitalopram 10mg ly from 06/07/23 to					
	-There was an entry f tablet daily with a sch of 8:00am. There was document	1's July 2023 MAR revealed: for escitalopram 10mg one eduled administration time ation escitalopram was					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
7.1.2.1.2.1.1			A. BUILDING: _	A. BUILDING:		
		FCL017018	B. WING		08/2	21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
TAVI OD E	AMILY CARE HOME #2	1136 BER	THA WILSON R	ROAD		
IAILORI	AWILT CARE HOWE #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 330	Continued From page	e 116	C 330			
C 330	Review of Resident # 08/01/23 to 08/18/23 -There was an entry f tablet daily with a sch of 8:00amThere was an entry f administered daily fro Observation of Reside on 08/18/23 at 10:49a with multi-dose packs that 30 escitalopram dispensed on 07/17/2 Telephone interview v facility's contracted pl 11:40am revealed: -The pharmacy had a 10mg daily for Reside-The pharmacy dispetablets on 03/21/23, 0 and 07/17/23The pharmacy did not discontinue escitalopted 2023The pharmacy would escitalopram 10mg if been received in the p-The pharmacy received facility staff would har-When a medication v pharmacy staff would multi-dose package of	r1's August 2023 MAR from revealed: for escitalopram 10mg one reduled administration time for escitalopram 10mg was also most of medication on hand arm revealed there was a box of medication with a label 10mg tablets were 13. with the Pharmacist at the harmacy on 08/18/23 at an order for escitalopram ent #1. Inseed 30 escitalopram 10mg 04/16/23, 05/15/23, 06/15/23, of receive an order to ram 10mg daily in March and have dispensed a discontinued order had pharmacy. Wed faxed orders from the in's office; sometimes the and deliver the prescription. Was discontinued, the pick up the monthly if medication, return to the e discontinued medication	C 330			
		emainder of the month and				
	Review of Resident #	1's MH Provider's visit note				

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DIVISION	n nealth Service Negu	ialion	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			_		
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	II E, ZIP CODE	
TAVLODE	AMILY CADE HOME #2	1136 BER	THA WILSON R	ROAD	
IAILORI	FAMILY CARE HOME #2	BLANCH,	NC 27212		
()(1) ID	SLIMMADV ST	ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
C 330	Continued From page	e 117	C 330		
	dated 05/02/23 revea	ladı			
	I	l "the people upstairs stole			
	her food card".				
	-Resident #1 demons	trated paranoid thoughts.			
	Review of Resident #	1's MH Provider's visit note			
	dated 06/19/23 revea	led Resident #1 reported			
		g from rooms in the facility.			
	Tricaring volcoe commi	g nom rooms in the lasting.			
	Review of Resident #	1's MH Provider's visit note			
	dated 08/03/23 revea				
	-	l ongoing hallucinations and			
	depression.				
	-Resident #1 was not	doing well due to group			
	home situation.				
	-MH Provider was reli	uctant to increase selective			
	serotonin reuptake inl	hibitors (SSRI)			
		ed to treat persistent or			
	severe depression) di	•			
		on SSRI medications.			
	Worsering payeriosis	on cord medications.			
	Ob	-ilit 00/40/22 h-tu			
		cility on 08/18/23 between			
		revealed loud arguing could			
		ent #1's room; Resident #1			
	was in her room alone	э.			
	Interview with the Sup	pervisor in Charge			
	(SIC)/Owner on 08/18	3/23 at 3:00pm revealed:			
	, ,	hings", she heard people			
talking that were not there.					
-Today, 08/18/23, Resident #1 stated a little girl					
	took a lizard out of he	•			
		o one had a right to steal			
	from her.				
		the SIC/Owner on 08/18/23			
	at 3:44:pm revealed:				
	-She knew Resident #	#1's escitalopram was			
	discontinued in March	າ 2023.			

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-She took Resident #1 to the MH Provider and

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLE	ETED
			7 20.12510			
			D 14/11/0			
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE ZIP CODE		
	101.52.1.01.1.00.1.2.2.1		, ,	,		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON F	ROAD		
		BLANCH	, NC 27212			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	NAIL	57.1.2
				,	-	
C 330	Continued From page	e 118	C 330			
	4-1-1 4	41				
	was told to discontinu					
		ffice faxed new orders to the				
	pharmacy.					
		would pick up the multi-dose				
	•	he pharmacy, repackage the				
		e discontinued medication				
		lose packs to the facility.				
		er if the pharmacy picked up				
		in March 2023 to remove				
	the discontinued med	lication and repackage the				
	remainder of the med	lications.				
	-If the medication was	s in the multi-dose pack, she				
	administered the med	dication.				
	-She started signing t	he June 2023, July 2023,				
	and August 2023 that	she was administering				
	_	e she noticed it was in the				
	multi-dose pack.					
		Provider had re-ordered the				
	medication.					
	Interview with the Adr	ministrator on 08/21/23 at				
	4:41pm revealed:					
	•	C/Owner to take new orders				
	to the pharmacy.	o, owner to take new cracio				
		d have asked the MH				
		ally send the prescription to				
	the pharmacy.	any seria the prescription to				
	-The SIC/Owner shou	uld have noticed the				
		n the multi-dose pack and				
		·				
	notified the pharmacy medication had been					
		ave become "sick" if she				
		nedication the MH provider				
	had discontinued.					
		with the SIC/Owner on				
	08/18/23 at 3:44pm.					
			1			

Attempted interview with Resident #1's Mental Health Provider on 08/21/23 at 10:17am was

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE :	
			7 50.25 10.	-		
		FCL017018	B. WING		08/	21/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		THA WILSON R NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 330	Continued From page	e 119	C 330			
	unsuccessful.					
	06/07/23 revealed: -Diagnoses included I post-traumatic stress -There was an order of elevated blood pressor. Review of Resident # administration record -There was an entry of at bedtime with a schoof 8:00pmThere was document administered at bedtin 07/30/23There was no docum administered on 07/3. Review of Resident # 08/01/23-08/17/23 revealed.	for prazosin 2mg (used for ure) 2 tablets every night. 3's July 2023 medication (MAR) revealed: or prazosin 2mg two tablets eduled administration time tation prazosin was me from 07/01/23 to nentation prazosin was 1/23.				
	administered at bedtin 08/17/23. Observation of Reside	ent #3's medications on				
		10:24am revealed there was lable for administration.				
	facility's contracted ph 11:40am revealed: -The pharmacy had a tablets at bedtime.	n order for prazosin 2mg 2 nsed prazosin on 06/19/23				

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DIVISION	n nealth Service Negu	lation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X		l ' '	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
FCI 047049		B. WING		00"	04/0000		
		FCL017018			08/2	21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
		1136 BERT	HA WILSON R	ROAD			
TAYLOR F	AMILY CARE HOME #2	BLANCH, I					
	OUR MAR DV OT	<u> </u>					
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S		(X5) COMPLETE	
TAG	•	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE AF		DATE	
				DEFICIENCY)			
C 220	Cantinuad Francisco	120	C 330				
C 330	Continued From page	e 120	C 330				
		on the original order so the					
	pharmacist sent a rec	quest to the ordering					
	physician on 06/19/23	3 for a prescription so the					
	pharmacy could dispersion 2023.	ense the medication in July					
		ent three requests to the					
		id had contacted the facility					
	to assist in getting a p						
	medication could be r						
		ot package prazosin 2mg in					
		that were dispensed on					
	07/17/23 because the	•					
	prescription had not b						
		ot have any information					
		cal Primary Care Provider					
	(PCP).						
	-	ot been notified Resident #3					
		could send a prescription for					
	refills for prazosin.						
	Based on observation	and record reviews					
	prazosin 2mg two tab						
		6/19/23 to 07/18/23, but					
		in 2mg tablets available for					
		7/19/23 to 08/17/23 because					
		ot been dispensed since					
	06/19/23.	ot been dispensed since					
	00/19/23.						
	Interview with Reside	nt #3 on 08/18/23 at 2:23pm					
	revealed:						
	 -He had not been rec weeks. 	eiving prazosin for several					
		last time he took prazosin.					
		he was not receiving					
	prazosin.	The was not receiving					
	ριαζυδίιι.						
	Telephone interview v	with a staff member at					
		office on 08/21/23 at 9:31am					
	revealed:	555 511 55/2 1/20 at 3.5 faili					
			1	T. Control of the con		1	

Division of Health Service Regulation

-Resident #3 had an order for prazosin 2mg 2

STATE FORM 6899 E4Y611 If continuation sheet 121 of 141

NAME OF PROVIDER OR SUPPLIER TAYLOR FAMILY CARE HOME #2 TAYLOR FAMILY CARE HOME #2 TAYLOR FAMILY CARE HOME #2 TAYLOR FAMILY CARE HOME #2 TAYLOR FAMILY CARE HOME #2 TAYLOR FAMILY CARE HOME #2 SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION PREFIX TAYLOR FAMILY CARE HOME #2 D PREFIX TAYLOR FAMILY CARE HOME #2 D PREFIX TAYLOR PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED TO THE APPROPRIATE DAVID PROVIDER'S PLAN OF CROSS ARE FERRINGED T	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER TAYLOR FAMILY CARE HOME #2 1136 BERTHA WILSON ROAD BLANCH, NC 27212 (X4) ID PRETIX TAG C 330 Continued From page 121 tablets at bedtime. -Prazosin could be used for elevated blood pressure or for hearing voices; she could not tell from reading the PCP's progress notes why Resident #3 was taking the medication. -Resident #3 was seen for the initial Mental Health wist on 07/25/23. -A prescription for prazosin should have been sent to the pharmacy. Interview with the SIC/Owner on 08/18/23 at 3.44 pm revealed: -She would have called the pharmacy if she had noticed the medication was not in the multi-dose pack. -She documented she administered prazosin because she thought the medication was in the multi-dose pack. -She did not know the pharmacy needed a new prescription to refill the medication was in the getting a new prescription for prazosin for Resident #3 as a local PCP, but she did not remember when she spoke to the pharmacy. -She thought the PCP worde new prescriptions and faxed them to the pharmacy. -She thought the PCP worde new prescriptions and faxed them to the pharmacy. -She thought the PCP worde new prescriptions and faxed them to the pharmacy. -She thought the PCP worde new prescriptions and faxed them to the pharmacy. -She thought the PCP worde new prescriptions and faxed them to the pharmacy. -She thought the PCP worde new prescriptions and faxed them to the pharmacy.	ECI 017018		B. WING		08/24/2022		
TAYLOR FAMILY CARE HOME #2 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY SUMMARY STATEMENT OF DEFICIENCY D PREFIX TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF DEFICIENCY D PREFIX TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMM						08/21/2023	
C 330 Continued From page 121 C 330 Continued From page 121 Each Detroitence is tablets at bedtime. Prazosin could be used for elevated blood pressure of the family value of the pharmacy of the initial Mental Health visit on 07/25/23. A prescription or not to the pharmacy. Interview with the SIC/Owner on 08/18/23 at 3.44-pm revealed: She did not know if the PCP sent an electronic prescription or not to the pharmacy if she had noticed the medication was not in the multi-dose pack. She did not know the pharmacy needed a new prescription to refill the medication and of the multi-dose pack. She did not know the pharmacy needed a new prescription for prazosin for Resident #3 had a local PCP, but she did not remember when she spoke to the pharmacy. She thought the PCP is prazosin for Resident #3 she did not know the pharmacy needed a new prescription or not to the pharmacy needed a new prescription to refill the medication. -The pharmacy did not contact her to assist in getting a new prescription for prazosin for Resident #3. -She informed the pharmacy Resident #3 had a local PCP, but she did not remember when she spoke to the pharmacy. Resident #3s and faxed them to the pharmacy at Resident #3s and faxed them to the pharmacy at Resident #3s and faxed them to the pharmacy at Resident #3s and faxed them to the pharmacy at Resident #3s and faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s and a faxed them to the pharmacy at Resident #3s	NAME OF PI	ROVIDER OR SUPPLIER					
SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY PILL PREFIX PROVIDERS PLAN OF CORRECTION COMMETTE PRECIDENCY MUST BE PRECEDED BY PILL PREFIX TAG PROVIDERS PLAN OF CORRECTION COMMETTE DATE PROVIDERS PLAN OF CORRECTION PROPRIATE DATE TAYLOR F	AMILY CARE HOME #2			OAD			
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 330 Continued From page 121 tablets at bedtime. -Prazosin could be used for elevated blood pressure or for hearing voices; she could not tell from reading the PCP's progress notes why Resident #3 was saking the medication. -Resident #3 was seen for the initial Mental Health visit on 07/25/23. -She did not know if the PCP sent an electronic prescription or not to the pharmacy. Interview with the SIC/Owner on 08/18/23 at 3:44:pm revealed: -She had not noticed prazosin was not in the multi-dose pack. -She would have called the pharmacy if she had noticed the medication was not in the multi-dose pack. -She did not know the pharmacy needed a new prescription to refill the medication. -The pharmacy did not contact her to assist in getting a new prescription for prazosin for Resident #3. -She informed the pharmacy Resident #3 had a local PCP, but she did not remember when she spoke to the pharmacy. -She thought the PCP wrote new prescriptions and faxed them to the pharmacy at Resident #3's	(V4) ID	SUMMARY ST			PROVIDER'S PLAN OF CORRECTION	ON (VE)	
tablets at bedtimePrazosin could be used for elevated blood pressure or for hearing voices; she could not tell from reading the PCP's progress notes why Resident #3 was taking the medicationResident #3 was seen for the initial Mental Health visit on 07/25/23A prescription for prazosin should have been sent to the pharmacy on 07/25/23She did not know if the PCP sent an electronic prescription or not to the pharmacy. Interview with the SIC/Owner on 08/18/23 at 3.44:pm revealed: -She had not noticed prazosin was not in the multi-dose packShe would have called the pharmacy if she had noticed the medication was not in the multi-dose packShe documented she administered prazosin because she thought the medication was in the multi-dose packShe did not know the pharmacy needed a new prescription to refill the medicationThe pharmacy did not contact her to assist in getting a new prescription for prazosin for Resident #3She informed the pharmacy Resident #3 had a local PCP, but she did not remember when she spoke to the pharmacyShe thought the PCP wrote new prescriptions and faxed them to the pharmacy at Resident #3's	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETE	
-Prazosin could be used for elevated blood pressure or for hearing voices; she could not tell from reading the PCP's progress notes why Resident #3 was taking the medication. -Resident #3 was seen for the initial Mental Health visit on 07/25/23. -A prescription for prazosin should have been sent to the pharmacy on 07/25/23. -She did not know if the PCP sent an electronic prescription or not to the pharmacy. Interview with the SIC/Owner on 08/18/23 at 3:44:pm revealed: -She had not noticed prazosin was not in the multi-dose pack. -She would have called the pharmacy if she had noticed the medication was not in the multi-dose pack. -She documented she administered prazosin because she thought the medication was in the multi-dose pack. -She did not know the pharmacy needed a new prescription to refill the medication. -The pharmacy did not contact her to assist in getting a new prescription for prazosin for Resident #3. -She informed the pharmacy Resident #3 had a local PCP, but she did not remember when she spoke to the pharmacy. -She thought the PCP wrote new prescriptions and faxed them to the pharmacy at Resident #3's	C 330	Continued From page	e 121	C 330			
Interview with the SIC/Owner on 08/21/23 at 10:10am revealed she had not spoken with Resident #3's provider regarding Resident #3 needing a new prescription for prazosin since she was made aware by the surveyor on 08/18/23 the	C 330	tablets at bedtimePrazosin could be us pressure or for hearin from reading the PCF Resident #3 was takin -Resident #3 was see Health visit on 07/25/2-A prescription for prasent to the pharmacy -She did not know if the prescription or not to solve the pharmacy -She had not noticed multi-dose packShe would have called noticed the medication packShe documented she because she thought multi-dose packShe did not know the prescription to refill the -The pharmacy did not getting a new prescription to refill the -The pharmacy did not getting a new prescription to refill the -The pharmacy did not spoke to the pharmacy -She thought the PCF and faxed them to the July 2023 appointment of the July 2023 appointment interview with the SIC 10:10am revealed she Resident #3's provide needing a new prescription and prescription and prescription to the pharmacy -She thought the PCF and faxed them to the July 2023 appointment of the pharmacy -She thought the PCF and faxed them to the July 2023 appointment of the pharmacy -She thought the SIC 10:10am revealed she resident #3's provide needing a new prescription and prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know the prescription to refill the -The pharmacy did not know	sed for elevated blood ag voices; she could not tell b's progress notes why ag the medication. en for the initial Mental 23. azosin should have been on 07/25/23. the PCP sent an electronic the pharmacy. c/Owner on 08/18/23 at prazosin was not in the ed the pharmacy if she had an was not in the multi-dose e administered prazosin the medication was in the e pharmacy needed a new the medication. of contact her to assist in oftion for prazosin for armacy Resident #3 had a d not remember when she by. of wrote new prescriptions e pharmacy at Resident #3's ant. c/Owner on 08/21/23 at the had not spoken with the regarding Resident #3 ription for prazosin since she	C 330			

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Division of Health Service Regulation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:		COMPLETED	
FCL017018 B. WING		08/21/2023	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
TAYLOR FAMILY CARE HOME #2			
BLANCH, NC 27212			
(7.1).5	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD I	(-/	
	FERENCED TO THE APPROPR		
	DEFICIENCY)		
C 330 Continued From page 122 C 330			
ordered and needed a new prescriptions.			
later in investitation Advantage on 00/04/00 at			
Interview with the Administrator on 08/21/23 at 4:41pm revealed:			
-The SIC/Owner should have realized the			
Prazosin was not in the multi-dose pack and			
notified the pharmacy to see why.			
-The SIC/Owner could assist in notifying the PCP			
for a prescription to refill the Prazosin.			
-She expected the SIC/Owner to administer			
medications as ordered.			
Refer to the interview with the SIC/Owner on			
08/18/23 at 3:44pm.			
00/10/23 at 3.44pm.			
3. Review of Resident #2's current FL-2 dated			
05/19/23 revealed:			
-Diagnoses included schizoaffective bipolar type, schizoaffective personality disorder, and anxiety			
disorder.			
-There was an order for Metformin (a medication			
used to treat high blood sugar levels) 1000mg			
daily at 5:00pm.			
-There was no order for finger stick blood sugar			
(FSBS).			
Desires of Desident #01- Drivers Over Provided			
Review of Resident #2's Primary Care Provider's			
(PCP) after-visit summary dated 08/03/23 revealed:			
-Metformin 1000mg was refilled.			
-Resident #2 also had diagnoses to include			
hyperlipidemia, diabetes mellitus, and			
hypertension.			
Review of Resident #2's August 2023 medication			
administration records (MAR) for			
08/01/23-08/18/23 revealed: There was an entry for Metformin 1000mg daily			
-There was an entry for Metformin 1000mg daily with a scheduled administration time of 5:00pm.			
-Metformin 1000mg was documented as			

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STATEMEN	T OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		08/2	21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
TAVLODE	AMILY CARE HOME #2	1136 BER	THA WILSON R	OAD			
IATLOR	AWILT CARE HOWE #2	BLANCH,	NC 27212				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
C 330	Continued From page	: 123	C 330				
	administered from 08 a handwritten note the discontinued 08/03/23						
	on 08/18/23 at 9:59ar	ent #2's medication on hand n revealed there was no ailable to be administered.					
	Metformin 1000mg available to be administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 08/18/23 at 10:14am revealed: -Metformin 1000mg was dispensed on 05/30/23 and 06/29/23; each dispensing was for a 30-day supplyMetformin 1000mg was not dispensed in August 2023 but she was not sure why the medication had not been filledThe pharmacy had changed computer systems and she thought it was an error on their behalfIf the facility staff had called the pharmacy to ask about the medication, they would have immediately dispensed the medicationResident #2's Metformin 1000mg would be sent to the facility today, 08/18/23.						
	PCP's office on 08/21 -Resident #2 was dial -Resident #2 had an a 1000mg to be adminis -If Resident #2's Metf the resident could have sugarsLong-term increased the resident's kidneys too high, the resident	active order for Metformin					

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-She thought Resident #2's Metformin had been

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DIVISION	n nealth Service Negu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FCL017018	B. WING		08/2	21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
		1136 BERT	HA WILSON R	ROAD		
TAYLOR F	AMILY CARE HOME #2	BLANCH, I	NC 27212			
	0.11.11.42.52.4.57	·		DROUGERIO DI AMI OF CORRECTIO		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROP		DATE
IAG	TREGOEM ON TOTAL	100 IBERTII TIIVO IIVI OTAMATION	TAG	DEFICIENCY)	10,112	
				, , , , , , , , , , , , , , , , , , ,		-
C 330	Continued From page	e 124	C 330			
	. •					
		e the pharmacy had not				
	delivered the medicat	ion.				
	-She had not seen an	order to discontinue				
	Resident #2's Metforr	nin.				
	-She had not called th	ne pharmacy to ask about				
	Resident #2's Metforr					
	TROOLGOTT // 2 O TRIOLIOTT					
	Intoniou with Booido	nt #2 on 00/10/22 of 1:20nm				
		nt #2 on 08/18/23 at 4:28pm				
	revealed:					
	•	tion in the morning and at				
	bedtime.					
	-He did not know wha	at medication he took; he				
	took whatever the SIC	C/Owner gave him.				
	-He did not know if his	s Metformin 1000mg had				
		the last time he took the				
	medication.					
	modication.					
	Interview with the Adr	ministrator on 08/21/23 at				
		Tillistrator on 00/21/23 at				
	4:43pm revealed:	: 1 1 1/OL NA 15				
		esident #2's Metformin had				
	not been administere					
	-She expected the SI	C/Owner to match the MAR				
	to the medications on	hand and if the medication				
	was not available, the	pharmacy should have				
	been contacted.					
	-She was concerned	because the resident was				
		d sugar could have "run up."				
	diabolio, and mo bloo	a sagar socia navo ran ap.				
	Pofor to the interview	with the SIC/Owner on				
		with the Sic/Owner on				
	08/18/23 at 3:44pm.					
		00110155				
		C/Owner on 08/18/23 at				
	3:44:pm revealed:					
	-She administered me	edications to all the				
	residents in the facility	y.				
		nedications entered on the				
	MAR to the list of med					
	containing the multi-d					
	~					
	-She made sure all th	e medications were	1			

Division of Health Service Regulation

available to administer.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017018	B. WING		09/24/2022
					08/21/2023
NAME OF PE	ROVIDER OR SUPPLIER		DDRESS, CITY, STA		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R I, NC 27212	OAD	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 330	Continued From page	125	C 330		
	medicationsMedication audits we the medication were constructed the laboration was a superior of the superi	after the resident took the re performed each month delivered. el on top of the multi-dose I the medications were in			
	administered as order including a resident, v schizophrenia, and es discontinued related thallucinations and padiscontinued order was pharmacy and the medispensed and admin 03/27/23-08/21/23 and have hallucinations of and conversing with conversion with conversion with	o an increase in aranoid thoughts, but the as not received by the edication continued to be distered daily from the resident continued to others stealing her items at there who were not there. Ited in a substantial risk of the resident, which			
		rovide an acceptable plan of nace with G.S. 131D-34 on			
	A SUMMARY SUSPE ISSUED ON AUGUS	ENSION OF LICENSE WAS F 23, 2023.			
C 342	10A NCAC 13G .1004 Administration	l(j) Medication	C 342		
	(j) The resident's med	Medication Administration dication administration accurate and include the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		7 50.12510.			
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TAYLOR F	FAMILY CARE HOME #2	1136 BERT BLANCH, I	THA WILSON R NC 27212	OAD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 342	(2) name of the medic (3) strength and dosa medication administe (4) instructions for ador treatment; (5) reason or justificat medications or treatmedocumenting the resu (6) date and time of a (7) documentation of medications or treatmomission, including re (8) name or initials of the medication or treasignature equivalent the documented and main administration record. This Rule is not met a Based on observation reviews, the facility farmedication administration for 2 of 3 sampled resumedication for involund diuretic, a hormone reanxiety medication, a medication for depress for reflux (#3). The findings are: 1. Review of Residen 11/29/22 revealed: -Diagnosis included uschizophreniaThere was an order finvoluntary movement	cation or treatment order; age or quantity of red; ministering the medication tion for the administration of ments as needed (PRN) and alting effect on the resident; administration; any omission of ments and the reason for the efusals; and the person administering atment. If initials are used, a to those initials is to be intained with the medication (MAR). as evidenced by: ms, interviews, and record illed to ensure the ation records were accurate sidents (#1, #3) including a mary movements (#1); and a eplacement medication, an ablood pressure medication, and blood pressure medication, and two medications at #1's current FL-2 dated and ifferentiated for Austedo (used to treat the 12 day and 12 mg twice daily. at 15 July 2023 medication	C 342		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF D			DDECC CITY CTA	TE ZID CODE	1 00/1 // 2010
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA THA WILSON R		
TAYLOR F	AMILY CARE HOME #2		NC 27212	COAD	
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S DI AN OE CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 342	Continued From page	e 127	C 342		
	-There was an entry f with a scheduled adm and 8:00pmThere was documen administered from 07.8:00amThere was no docum administered from 07.8:00pm. Observation of Reside on 08/12/23 at 10:40g was packaged in the and available for adm. Telephone interview of facility's contracted pl. 11:40am revealed: -The pharmacy had a twice daily for Reside -The pharmacy dispetablets on 06/15/23 at 10:40g was packaged.	for Austedo 12mg twice daily ninistration time of 8:00am ted Austedo 12mg was /01/23 to 07/31/23 at nentation Austedo 12mg was /01/23 to 07/31/23 at ent #1's medication on hand om revealed Austedo 12mg multi-dose packs twice daily ninistration. with the Pharmacist at the harmacy on 08/18/23 at an order for Austedo 12mg ent #1. nsed 60 Austedo 12mg			
	on 08/21/23 at 10:50a -She administered Re	am revealed: esident #1 Austedo 12mg at			
	8:00pm; it was in her -She did not know she Austedo at 8:00pm.	multi-dose pack. e did not sign the MAR for			
	-She needed to be su when a medication wa	re she signed the MAR as administered.			
	Refer to the interview 08/21/23 at 4:41pm.	with the Administrator on			
	2. Review of Residen 06/07/23 revealed: -Diagnoses included schizophrenia, and po				

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disorder.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
FCL017018		B. WING		08/2	1/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TAVLODE	AMILY CARE HOME #2	1136 BERT	HA WILSON R	OAD		
IATLOR	AMILY CARE HOME #2	BLANCH, N	IC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342	Continued From page	e 128	C 342			
C 342	-There was an order for (used to treat blood purchase was an order for the treat anxiety) three times. There was an order for treat anxiety) three times. There was an order for treat bipolar disorder). There was an order for treat heartburn) twice. There was an order for form the treat depression at burning treat depression at burning treat depression at burning treat depression. There was an entry for daily with a scheduled 8:00am. There was no document administered on 06/26 8:00am. There was an entry for scheduled administration. There was an entry for scheduled administration. There was an entry for scheduled administration. There was no document administered on 06/26 8:00am. There was no document administered from 06/26 8:00am. There was no document administered from 06/26 8:00am. There was no document administered from 06/26 8:00am. There was no document administered from 06/26 8:00am.	for spironolactone 50mg ressure) 5 tablets daily. For Estrace 5mg (used for to therapy) daily. For buspirone 10mg (used to mes daily. For olanzapine 5mg (used to mes daily. For famotidine 20mg (used to daily. For pantoprazole 40mg for pantoprazole 40mg for fluoxetine 20mg (used to edtime. 3's June 2023 medication (MAR) from 06/08/23 to for spironolactone 50mg dadministration time of the dath of the daily of the dath of th	C 342			
		eduled administration time nd 8:00pm.				

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administered on 06/27/23 at 8:00pm to 06/29/23

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
AND LEW OF CONTROL	BENTI TO THOMBELL	A. BUILDING: _		J GOWN EE	
FCL017018		B. WING		08/21	1/2023
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
	1136 BEF	RTHA WILSON R	ROAD		
TAYLOR FAMILY CARE HOME #2	BLANCH	, NC 27212			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 342 Continued From page	e 129	C 342			
at 8:00am. -There was no docum administered from 06 2:00pm and 06/29/23 8:00pm. -There was an entry f bedtime with a sched 8:00pm. -There was documen administered from 06 8:00pm. -There was no docum administered from 06 06/30/23 at 8:00pm. -There was an entry f daily with a scheduled 8:00am and 8:00pm. -There was documen administered on 06/2 at 8:00am. -There was no docum administered from 06 8:00am and 06/29/23 8:00pm. -There was an entry f bedtime with a sched 8:00pm. -There was documen administered on 06/2 8:00pm. -There was no docum administered from 06 06/29/23 to 06/30/23 -There was no docum administered from 06 06/29/23 to 06/30/23 -There was an entry f with a scheduled administered on 06/2 8:00am.	nentation buspirone was /08/23 to 06/27/23 at at 2:00pm to 06/30/23 at or olanzapine 5mg at uled administration time of tation olanzapine was /27/23 to 06/29/23 at nentation olanzapine was /08/23 to 06/26/23 and or famotidine 20mg twice of administration time of tation famotidine was 7/23 at 8:00pm to 06/29/23 nentation famotidine was /08/23 to 06/27/23 at at 8:00pm to 06/30/23 at or fluoxetine 20mg at uled administration time of tation fluoxetine was 7/23 and 06/28/23 at nentation fluoxetine was 7/23 and 06/28/23 at nentation fluoxetine was 7/23 and 06/28/23 at nentation fluoxetine was 7/23 and 06/26/23 and at 8:00pm. The proportion of the proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm. The proposed fluore was /08/23 to 06/26/23 and at 8:00pm.	C 342			

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administered from 06/08/23 to 06/27/23 and

STATE FORM 6899 E4Y611 If continuation sheet 130 of 141

DIVISION	n nealth Service Negu	ialion					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		1 ' '	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		COMPLETED	
		B. WING					
		FCL017018	B. WING		08/2	21/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE			
		1136 BER	THA WILSON R	ROAD			
TAYLOR F	AMILY CARE HOME #2	BLANCH,		TOAD			
		·	110 2/212	T			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO		(X5) COMPLETE	
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APP		DATE	
17.0		,	IAG	DEFICIENCY)			
				†			
C 342	Continued From page	e 130	C 342				
	06/30/23 at 8:00am.						
	00/30/23 at 0.00am.						
	Observation of Reside	ent #3's medication on hand					
	-	om revealed there was					
		e, buspirone, olanzapine,					
	· · · · · · · · · · · · · · · · · · ·	zole, and fluoxetine were					
		-dose packs and available					
		-dose packs and available					
	for administration.						
	Interview with Poolds	nt #2 on 00/10/22 at 4:27nm					
		nt #3 on 08/18/23 at 4:27pm					
	revealed:						
		ght him his medications.					
		I take them and sometimes					
		they were always available					
	to take.						
		vith the Pharmacist at the					
	*	harmacy on 08/18/23 at					
	11:40am revealed:						
		n order for spironolactone					
	50mg 5 tablets daily.						
	-The pharmacy dispe	nsed 100 tablets on					
	08/16/23.						
	-The pharmacy had a	n order for Estrace 5mg					
	daily.						
	-The pharmacy dispe	nsed 30 tablets on 08/16/23.					
	-The pharmacy had a	n order for buspirone 10mg					
	three times daily.						
	-The pharmacy dispe	nsed 90 buspirone on					
	07/26/23.	·					
	-The pharmacy had a	n order for olanzapine 5mg					
	at bedtime.						
	-The pharmacy dispe	nsed 30 olanzapine on					
	07/26/23.	1					
		n order for famotidine 20mg					
	twice daily.	1.101 for famoualite Loning					
		nsed 40 famotidine on					
	08/16/23.	nood to idinionalite on					
		n order for pantoprazole					
	- me pharmacy had a	in order for partioprazole	1				

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40mg daily.

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		
			D. WING			
		FCL017018	B. WING		08/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TWANE OF T	TOVIDER OR OUT FIELD		, ,	•		
TAYLOR F	AMILY CARE HOME #2		RTHA WILSON R	COAD		
		BLANCH	, NC 27212			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE DAIE	
				52.10.2.101)		
C 342	Continued From page	e 131	C 342			
	-The pharmacy disne	nsed 20 pantoprazole on				
	08/16/23.	naca zo pantoprazole on				
		n order for fluoxetine 20mg				
	at bedtime.	in order for huoxetine zonig				
	-The pharmacy dispe	nsed 30 fluovetine on				
	07/26/23.	rised 50 lidoxetille off				
	01120123.					
	Interview with the SIC	C/Owner on 08/21/23 at				
	10:50am revealed:	JOWNER ON 00/21/23 at				
		nitted to the facility on				
		filled to the facility on				
	06/07/23.	ations and the lune 2002				
		ations and the June 2023				
		n the facility on 06/08/23.				
	•	t #3's medication in the				
		nd misplaced the June 2023				
	MAR.					
		nting on the MARs when she				
	located them.					
		d his medications starting on				
	-	n a multi-dose pack and				
	labeled for morning o	r evening.				
		with the Administrator on				
	08/21/23 at 4:41pm.					
		ministrator on 08/21/23 at				
	4:41pm revealed:					
		uld document on the MAR				
	immediately after the	medications were				
	administered.					
		Owner to place the MARs in				
	_	ould not get misplaced; she				
	did not remember wh					
	SIC/Owner to place the	ne MARs in a notebook.				
C 353	10A NCAC 13G .1006	6 (b) Medication Storage	C 353			
		6 Medication Storage				
	(b) All prescription ar	nd non-prescription				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND I LANG	. John Lorion	SEATH IS AIGH HOMBER.	A. BUILDING: _		00.000	
		FCL017018	B. WING		08/21/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
TAVI OD F	AMILY CARE HOME #0	1136 BER	THA WILSON R	OAD		
IATLUR	AMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET	Ë
C 353	Continued From page	: 132	C 353			
C 353	medications stored by requiring refrigeration locked security excep physical supervision of medication administra. This Rule is not met. Based on observation interviews, the facility medications for 1 of 5 in a locked container. The findings are: Observation of the medication cabinet. The medication cabinether were 5 plastic top of each other on to cabinet. One of the 5 plastic round white tablets, 1 one beige and greenenther was a residententher was no facility. Interview with the Super (SIC)/Owner on 08/21. A resident refused to night on 08/17/23. She thought she three-she disposed of median plastic bag and drop in the second of th	the facility, including those, shall be maintained under the when under the direct of staff in charge of ation. as evidenced by: as evidenced by: as evidenced by: as record review, and failed to ensure or residents (#3) were stored redication cabinet on evealed: and the top of the medication medication cups stacked on the top of the medication medication cups contained 5 square beige tablet, and capsule. t seated in the living room.	C 353			
	neededMedications should r residents may take th	not be left out because other em.				
	Review of a resident's	s medication administration	1			

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record (MAR) for 08/18/23 revealed the

STATE FORM 6899 E4Y611 If continuation sheet 133 of 141

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
TAYLOR F	AMILY CARE HOME #2		HA WILSON R	OAD	
		BLANCH, I	NC 2/212		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 353	Continued From page	e 133	C 353		
	medications observed medications listed for	•			
	Interview with the Administrator on 08/21/23 at 4:41pm revealed: -Medications should be given to the residents as soon as they were prepared.				
	-If the resident refuse	d to take the medications,			
	the SIC/Owner should place the medications in the medication cabinet and try again in 10 to 15 minutes.				
	-After 3 attempts of tr				
	of in a drug buster.	ications should be disposed			
C 367	10A NCAC 13G .1008	B(a) Controlled Substances	C 367		
	10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.				
	This Rule is not met TYPE B VIOLATION	as evidenced by:			
	interviews, the facility readily retrievable rec substances by docum administration, and di				
	The findings are:				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
		FCL017018	B. WING		08/21	1/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00/2	
TAYLOR F	FAMILY CARE HOME #2	1136 BERT	HA WILSON R	OAD		
BLANCH, I		NC 27212		T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 367	Continued From page	: 134	C 367			
	11/29/22 revealed: -Diagnosis included uschizophreniaThere was an order treat anxiety) every 8 Review of Resident #	for lorazepam 1mg (used to hours as needed (PRN). 1's March 2023 medication				
	administration record (MAR) from 03/28/23 to 03/31/23, April 2023 MAR, May 2023 MAR, June 2023 MAR, July 2023 MAR, and August 2023 MAR from 08/01/23 to 08/18/23 revealed: -There was an entry for lorazepam 1mg every 8 hours PRNThere was no documentation on Resident #1's					
	MAR lorazepam was administered in March 2023, April 2023, May 2023, June 2023, July 2023, or August 2023.					
	Review of Resident #1's controlled substance count sheet (CSCS) on 08/18/23 at 10:44am revealed:					
	read lorazepam 1mg each CSCS.	with a pharmacy label that every 8 hours as PRN on				
		ts dispensed on 03/28/23. nentation on either CSCS				
	#1 on 08/18/23 at 10: -There was a bubble that read lorazepam? -The bubble pack was packs dispensed on 0: -There were 12 loraze the second bubble page.	pack with a pharmacy label Img every 8 hours PRN. s labeled 2 of 2 bubble 03/28/23. epam tablets dispensed in				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		FCL017018	B. WING		08/21/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
TAVI OD F	AMILY CADE HOME #0	1136 BER	THA WILSON R	OAD	
IATLOR	FAMILY CARE HOME #2	BLANCH,	NC 27212		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 367	Continued From page	e 135	C 367		
	bubble pack.				
	Telephone interview of facility's contracted plus 11:40am revealed: -The pharmacy had a every 8 hours as neeThe pharmacy dispetablets on 03/28/23. -The pharmacy dispetablets in one bubble lorazepam 1mg tableThe pharmacy sent a pack. -The CSCS was to be aide to keep track of the factor of the control of the cont	nsed 42 lorazepam 1mg nsed 30 lorazepam 1mg pack and dispensed 12 ts in a second bubble pack. a CSCS with each bubble e used by the medication the controlled substance.			
	administered lorazepa	am to Resident #1.			
	#1 on 08/21/23 at 10 -There were two bubb 03/28/23 for lorazepa needed for Resident; -One bubble pack wa	ole packs dispensed on m 1mg every 8 hours as #1. s labeled as 1 of 2. epam tablets dispensed in 17 of 30 tablets were			
	-The second bubble pro-There were 12 loraze	pack was labeled as 2 of 2. epam tablets dispensed in			

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remaining in the bubble pack.

STATE FORM 6899 E4Y611 If continuation sheet 136 of 141

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SI COMPLE	
		ECI 047049	B. WING		00/2	4/2022
		FCL017018			08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER		ORESS, CITY, STA			
TAYLOR F	FAMILY CARE HOME #2	BLANCH,	THA WILSON R NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 367	Continued From page	e 136	C 367			
	at 10:18am revealed: -She placed the bubb the closet in the denShe had administere locked the medication medication in her han side of the houseShe placed the bubb closet in the den to ke to the residents' living -She had forgotten th closet in the denShe had administere but had not documen medication. Interview with the Adr 4:41pm revealed: -When a controlled su the SIC/Owner should the CSCSDocumentation on th controlled substance -Documentation on th Primary Care Provide how often the medica -She expected the SI the MAR and CSCS e substance was admin The facility failed to e retrievable record of a documenting on the M time the medication w	alle pack of lorazepam 1mg in and a tablet to Resident #1, in cabinet and had the ad when she returned to her alle pack of lorazepam in the greep it safe until she returned a quarters. The lorazepam 1mg was in the ad lorazepam to Resident #1 and the she administered the administered the administered the administered and document on the MAR and the CSCS kept track of the medication. The MAR would let the fer (PCP) know when and the tion was administered. C/Owner to document on the medication are there was a readily a controlled substance by MAR and the CSCS each was administered, leaving 13 ts unaccounted for. This				

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B Violation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		FCL017018	B. WING		ns	/21/2023
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STAT	TE ZIP CODE	1 00	12025
			THA WILSON R			
IATLOR	FAMILY CARE HOME #2	BLANCH,	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 367	Continued From page	e 137	C 367			
	A SUMMARY SUSPE	ENSION OF LICENSE WAS T 23, 2023.				
	A Plan of Protection v	vas not obtained.				
C 368	10A NCAC 13G .1008	3 (b) Controlled Substances	C 368			
	10A NCAC 13G .1008	8 Controlled Substances				
	Schedule II medication	n location or container. If ons are stored together in a Schedule II medications				
	This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure controlled medication, including an anti-anxiety medication, was stored under a double lock.					
	The findings are:					
	times between 8:00ar -The residents went in (SIC)/Owner's private	n and out of the Supervisor				
	private residence on (revealed: -The SIC/Owner wenterieved a bubble pa	oset in the SIC/Owner's 08/21/23 at 10:15 am t to the closet in her den and ck with a pharmacy label 1mg (used to treat anxiety)				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S	
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
TAYLOR F	AMILY CARE HOME #2		THA WILSON R	COAD		
		<u> </u>	NC 27212			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 368	Continued From page	÷ 138	C 368			
	every 8 hours PRN the The bubble pack was dispensed on 03/28/2 - There were 30 loraze the first bubble pack There were 17 of 30 bubble pack. Interview with the Phacontracted pharmacy revealed: - The pharmacy dispelorazepam on 03/28/2 12 tablets in card 2 Lorazepam was a corequired under law to secure area. Interview continued w 08/21/23 at 10:18am - Controlled substance locks The closet door in the was located was not lender the placed the bubben the closet in the den She placed the bubben closet in the den She placed the bubben closet in the den to ke to the resident's living	nat belonged to Resident #1. s 1 of 2 bubble packs 23. epam tablets dispensed in tablets remaining in the armacist at the facility's on 08/18/23 at 11:40am nsed 42 tablets of 23; 30 tablets in card 1 and ontrolled substance and was be kept in a locked and with the SIC/Owner on revealed: es should be stored under 2 e den where the lorazepam locked. Deen in the closet about one ole pack of lorazepam 1mg in the day at ablet to Resident #1, in cabinet and had the old when she returned to her ole pack of lorazepam in the deep it safe until she returned				
		ministrator on 08/21/23 at				

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4:41pm revealed:

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		FCL017018	B. WING		08/2	1/2023
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00:2	
TAYLOR F	AMILY CARE HOME #2	1136 BERTI BLANCH, N	HA WILSON R IC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 368	2 locksAnyone could have to substance when not led to the controlled substances	nces should be locked under aken the controlled	C 368			
C 613	Control Policies & Pro 10A NCAC 13G .1707 PREVENTION AND OPROCEDURES (d) In accordance with Subchapter and G.S. shall ensure all staff a hire and annually on the	I INFECTION CONTROL POLICES &	C 613			
	facility failed to ensure who administered me state-mandated infect. The findings are: Review of Staff A's, S (SIC)/Owner, person -She was hired in Apr -She worked as a me	ews and interviews, the e 1 of 1 sampled staff (A), dications, completed the tion control training annually. upervisor in Charge nel record revealed: il 1985.				

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STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S COMPLI	
		FCL017018	B. WING		08/2	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
TAYLOR FAMILY CARE HOME #2 1136 BERT BLANCH,			HA WILSON R NC 27212	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 613	Continued From page	: 140	C 613			
	-There was no other of	ng dated November 2021. documentation the ion control training was				
	revealed: -She was the SIC/Ow -She did not know the annual infection control -She thought she was control class soon, bu -The infection control the facility's contracte -The class was offere -She had the class las pick up her certificate Interview with the Adr 4:41pm revealed: -The facility's contract infection control in-se	e last time she had the ol training. E scheduled for an infection at she did not know when. It she did not know when. It she did not know when. It she did not know when. It she did not know when. It she did not know when. It she did not know when. It she did not know when. It she did not know when. It she did not know when. It she last time the had the did not know when. It she d				
	-She did not know the in-service was in Nov -She was responsible	last infection control				

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