STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017018	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey on August 18, 2023 and August 21, 2023.	C 000		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 5 sampled residents (#5) who had a diagnosis of dementia and did not respond to the fire drill. The findings are: Review of the facility's license effective 01/01/23 revealed the facility was licensed for a capacity of 6 ambulatory residents. Review of the facility's census on 08/18/23 revealed that 5 residents resided at the facility. Review of the facility's fire drill rehearsal record	C 022		

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C 022	Continued From page 1	C 022		

dated 01/05/23 at 9:00pm revealed:
-The fire drill was conducted by the Supervisor-in-Charge (SIC)/Owner.
-Two residents left through the front door and went to the tree in the front yard.
-The drill was completed without difficulty at 9:25pm.

Review of the facility's fire drill rehearsal record dated 03/03/23 at 10:30am revealed:
-The fire drill was conducted by the SIC/Owner.
-Two residents left through the front door and went to the tree in the front yard.
-The drill was completed without difficulty at 10:45am.

Review of the facility's fire drill rehearsal record dated 06/01/23 at 4:00pm revealed:
-The fire drill was conducted by the SIC/Owner.
-Two residents left through the front door and went to the tree in the front yard.
-The drill was completed without difficulty at 4:25pm.

Review of Resident #5's current FL-2 dated 11/07/22 revealed diagnoses included dementia without behavioral disturbance, hypertension, and hyperlipidemia.

Review of Resident #5's Resident Register revealed an admission date of 08/07/20.

Review of Resident #5's Care Plan dated 11/07/22 revealed:
-Resident #5 was sometimes disoriented.
-Resident #5 had significant memory loss and must be directed.

Observation of a fire drill on 08/18/23 between 9:00am-9:06am revealed:

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-The SIC/Owner set off a fire alarm in the hallway of the facility.
-The alarm was loud and audible throughout the facility.
-Resident #5 did not exit the facility.
-Resident #5 was ambulating in the hallway toward her room.
-Resident #5 entered her bedroom during the fire drill.

Interview with Resident #5 on 08/18/23 at 9:02am revealed:
-She stayed where she was when the noise started.
-She did not know what to do when the noise started.
-She did not remember practicing fire drills.

Observation of the facility on 08/18/23 at 9:57am revealed the fire alarm randomly alarmed and Resident #5 did not exit the facility.

Observation of the facility on 08/18/23 at 10:06am revealed the fire alarm randomly alarmed; Resident #5 was sitting in a chair in the living room and did not move from the chair.

Telephone interview with Resident #5's legal guardian on 08/21/23 at 8:45am revealed:
-Resident #5 had a diagnosis of dementia.
-People with dementia had "up and down days" meaning some days Resident #5 may be able to follow directions and other days she would not.
-Resident #5 would need to be prompted to make sure she knew what was going on and to safely exit the facility.

Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed:
-All of the residents at the facility were

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C 022	Continued From page 3 ambulatory. -If a resident was not ambulatory, she would not accept the resident at the facility. -She thought ambulatory meant the resident walked without a walker. -No one had told her about any other reason a resident would be considered non-ambulatory. -Resident #5 was the only resident with a diagnosis of dementia. -Resident #5 could be told something and two minutes later the resident would not remember. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -She was not aware the resident did not exit the facility during a fire drill. -She had not observed any fire drills at the facility. -She did not know verbal prompting could not be done during the fire drills. Attempted telephone interview with Resident #5's Primary Care Provider (PCP) on 08//21/23 at 12:22pm was unsuccessful. _____ The facility failed to ensure the building was equipped and maintained in accordance with the facility's license capacity to allow a resident residing in the facility, who had cognitive deficits (#5), to evacuate the facility independently in case of an emergency such as a fire. This failure was detrimental to the health, safety, and well-being of the resident and constitutes a Type B Violation. _____ 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 022		

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C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors accessible to residents, who wandered away from the facility (#1) and a resident who was sometimes disoriented (#5), had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Observation of the entrance/exit door to the facility on 08/18/23 at various times between 8:05am-6:00pm revealed no alarm sounded when the door to the facility was opened and closed.	C 069		

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C 069	Continued From page 5 Observation of a second entrance/exit door to the facility on 08/18/23 at 2:43pm revealed the door was located on the bedroom hallway and no alarm sounded when the door was opened and closed. Interview with a resident on 08/18/23 at 2:37pm revealed: -If he could not sleep, he went outside during the night and there were no alarms on the doors. -No one came to check on him when he went outside during the night. Interview with a second resident on 08/18/23 at 2:28pm revealed he had never heard an alarm on either door. Interview with a third resident on 08/18/23 at 2:36pm revealed: -He had used the front and back door to go outside. -He had never heard an alarm sound when either door was opened. 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. Review of Resident #1's Resident Register revealed an admission date of 05/21/21. Review of Resident #1's Care Plan dated 11/29/23 revealed: -Resident #1 was oriented. -Resident #1 had adequate memory. Review of Resident #1's Mental Health (MH) Provider's visit note dated 03/27/23 revealed: -The Supervisor in Charge (SIC) /Owner reported	C 069		

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C 069	Continued From page 6 Resident #1 had been more irritable the past week related to paranoid delusion. -Resident #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 building. -She 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 revealed:	C 069		

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-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.
-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 would 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 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 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 the facilty 3 times, 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.

2. Review of Resident #5's current FL-2 dated 11/07/22 revealed diagnoses included dementia without behavioral disturbance, hypertension, and

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C 069	Continued From page 8	C 069		

hyperlipidemia.

Review of Resident #5's Resident Register revealed an admission date of 08/07/20.

Review of Resident #5's Care Plan dated 11/07/22 revealed:
-Resident #5 was sometimes disoriented.
-Resident #5 had significant memory loss and must be directed.

Interview with Resident #5 on 08/18/23 at 2:26pm revealed:
-She had never heard an alarm on the door in the living room.
-She used the door in the living room to exit the building; she did not know there was another door to exit the building.

Telephone interview with Resident #5's legal guardian on 08/21/23 at 8:45am revealed:
-Resident #5 had a diagnosis of dementia.
-People with dementia had "up and down days" meaning some days Resident #5 may be able to follow directions and other days the resident would not.
-She would expect the facility to have some type of alert system to know when Resident #5 went in and out of the facility to ensure the resident was safe.

Telephone interview with Resident #5's Primary Care Provider's (PCP) nurse on 08/21/23 at 12:33pm revealed:
-Resident #5 had a diagnosis of dementia.
-Resident #5 would require supervision because of her dementia and for her overall safety to ensure the resident did not "wander off."
-She would think it was necessary to have some type of alarm in place to monitor Resident #5 for

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C 069	Continued From page 9 her safety. Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -She did not think Resident #5 would wander off. -When Resident #5 went outside, she came right back in because she thought the resident realized she did not want to get lost. -Even when they went on outings, Resident #5 stayed right with her. Attempted telephone interview with Resident #5's MH provider on 08/21/23 at 10:05am was unsuccessful. 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. _____ Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -The alarm system on the exit doors of the resident's living quarters did not work. -She cut the alarm system off about two years ago because of the cost. -The door alarm system was for her safety for being robbed, not for the resident's safety. -If there was an alarm on the doors accessible by the residents, it would go off all the time. -There was a sounding device in addition to the alarms that was placed on the doors to know when the door was opened, but one of the residents broke it off. -She could not recall when the sounding device was broken off the door, but it was recently. -The sounding device the resident broke off could not be heard in her residence if she was in her bedroom and she would not know if the residents	C 069		

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C 069	Continued From page 10 went outside. -She did not go to bed until about 2:00am every night. -She made rounds in the facility around 12:00am to make sure all the doors were locked and the residents were in their rooms. -The residents knew the doors were supposed to be locked after 10:00pm. -None of the residents "really went outside late at night." Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -She thought the facility had door alarms. -She did not know the alarms had been turned off. -She heard "beeps" when she was at the facility. -The exit alarms must go back on the exit doors in the facility. -She had left a voicemail for the security system company that provided security and video for another facility in which she was the Administrator. Refer to Tag 243, 10A NCAC 13F. 0901(b) Personal Care and Supervision (Type A1 Violation). _____ The failure of the facility to ensure the alarms on the exit doors to the facility had an audible sounding device when activated resulted in a resident (#1) eloping from the facility at least four times in four days; and another resident (#5), who was intermittently disoriented, having access to the door and possibly eloping. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on	C 069		

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C 069	Continued From page 11 08/18/23. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023.	C 069		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure that fire evacuation plans were rehearsed at least four times yearly. The findings are: Review of the facility's census on 08/18/23 revealed that 5 residents resided at the facility. Review of the facility's fire drill rehearsal record dated 01/05/23 at 9:00pm revealed: -The fire drill was conducted by the Supervisor-in Charge (SIC)/Owner.	C 100		

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C 100	Continued From page 12 -Two residents left through the front door and went to the tree in the front yard. -Drill completed without difficulty at 9:25pm. Review of the facility's fire drill rehearsal record dated 03/03/23 at 10:30am revealed: -The fire drill was conducted by the SIC/Owner. -Two residents left through the front door and went to the tree in the front yard. -Drill completed without difficulty at 10:45am. Review of the facility's fire drill rehearsal record dated 06/ 01/23 at 4:00pm revealed: -The fire drill was conducted by the SIC/Owner. -Two residents left through the front door and went to the tree in the front yard. -Drill completed without difficulty at 4:25pm. Observations of a fire drill on 08/18/23 between 9:02am-9:06am revealed: -The SIC/Owner set off a fire alarm in the hallway of the facility. -The alarm was loud and audible throughout the facility. -No residents exited the facility. Observation of the facility on 08/18/23 at 12:14pm revealed the fire alarm randomly alarmed, and no residents exited the facility. 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. Observation of Resident #1 on 08/18/23 between 9:02am and 9:06am revealed: -Resident #1 was sitting on her bed in her bedroom. -Resident #1 continued to stay in her room and	C 100		

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C 100	Continued From page 13 did not exit when the fire alarm sounded. Interview with Resident #1 on 08/18/23 at 9:02am revealed: -She did not know what was going on when the noise sounded. -She wanted the noise to stop. -She did not know this was a fire drill. -The facility did not have fire drills often. 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. 2. Review of Resident #2's current FL-2 dated 05/19/23 revealed diagnoses included schizoaffective bipolar type, schizoaffective personality disorder, and anxiety disorder. Observation of Resident #2 on 08/18/23 at 9:02am-9:06am revealed: -Resident #2 was sitting in a chair in his room when the fire alarm was sounded in the hallway outside of his door. -Resident #2 did not move but continued to sit in his chair in his room. Interview with Resident #2 on 08/18/23 at 9:03am revealed: -He knew the alarm was a fire alarm. -When he heard the alarm, he was supposed to feel his door to see if it was hot, lay down on the floor, and look for the exit. -He did not exit the facility because he thought it was "role play." -He did not see anyone else leave the facility. -He did not recall the facility having a fire drill since he moved in, "a couple of months ago."	C 100		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 100	Continued From page 14 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 alarm. -Someone 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 2023. -The SIC/Owner had never talked to him about fire drills. 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. 4. Review of Resident #4's current FL-2 dated 10/27/22 revealed diagnoses included mental health disorder, attention-deficit/hyperactivity disorder (ADHD), and intellectual developmental disability.	C 100		

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C 100	Continued From page 15 Observation of Resident #4 on 08/18/23 at 9:05am revealed he was sitting on his bed; he did not exit his room while the fire alarm was alarming. Interview with Resident #4 on 08/18/23 at 9:05am revealed: -He did not know what the alarm was for. -There 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 interview with the Administrator on 08/21/23 at 4:43pm. 5. Review of Resident #5's current FL-2 dated 11/07/22 revealed diagnoses included dementia without behavioral disturbance, hypertension, and hyperlipidemia. Observation of Resident #5 during the fire drill on 08/18/23 at 9:00am revealed: -Resident #5 was ambulating in the hallway toward her room. -Resident #5 entered her bedroom during the fire drill and stayed there. Interview with Resident #5 on 08/18/23 at 9:02am revealed: -She stayed where she was when the noise started. -She did not know what to do when the noise started. -She did not remember practicing a fire drill. Refer to interview with the SIC/Owner on 08/18/23 at 3:00pm.	C 100		

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C 100	Continued From page 16 Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm. _____ Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -She performed fire drills every 3-4 months. -When a new resident moved in, she would tell the resident if they heard a fire alarm they were to exit the closest door. -When she performed fire drills in the past, she set the alarm off, and none of the residents responded. -She would tell the residents to get out and they still did not go out. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -She was not aware the residents did not exit the facility during fire drills. -She asked the SIC/Owner if she was completing fire drills and was told she was. -She had not observed any fire drills at the facility. -She had not asked for details about the fire drills, just if the fire drills were being done. _____ This failure of the facility to conduct at least four fire rehearsals yearly resulted in the residents not knowing how to respond to a fire alarm should a fire occur within the facility nor how to exit the facility during a fire which was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ 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 100		

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C 131	Continued From page 17	C 131		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B, C) who administered medications, completed a medication clinical skills checklist and had documentation they had successfully passed the written state medication administration examination, and completed the 5, 10, or 15-hour medication aide (MA) training course or had verification of previous as a MA before administering medication to residents. The findings are: 1. Review of Staff B's personnel record revealed there was no record to review and no documentation of completion of 5, 10, 15-hour medication training, medication clinical skills checklist or previous employment verification. Interview with Staff B on 08/21/23 at 2:18pm revealed: -She had taken and passed the MA test when she owned a facility. -She was a MA and assisted the SIC/Owner when	C 131		

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she was needed.
-The SIC/Owner was the in hospital overnight on 07/30/23 and she administered the evening medications to the residents.
-She did not have a personnel record; she did not need one because she would be going home in a few weeks.

Interview with two residents on 08/21/23 at 2:00pm revealed Staff B administered medications when she worked.

Interview with the SIC/Owner on 08/21/23 at 2:18pm revealed:
-Staff B owned a facility, but it was closed.
-Staff B took all the requirements for a medication aide years ago, and she was certified to administer medications.
-Staff B's personnel record was at her closed facility.
-She did not know she needed to verify Staff B had administered medications prior to administering medications to the residents, since she knew Staff B had administered medications in another facility.

Interview with the Administrator on 08/21/23 at 5:28pm revealed:
-Staff B was a relative of the SIC/Owner.
-Staff B worked as a SIC when she was in the facility.
-Staff B had a personnel record from previously owning a facility, but she had not brought the personnel record to this facility.
-She thought Staff B had brought her personnel record to the facility.
-The SIC/Owner and the Administrator were responsible for making sure each staff had medication aide training.
-All staff should have required testing done prior

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C 131	Continued From page 19	C 131		

to working with the residents.
-She did not audit personnel records.

2. Review of Staff C's personnel record revealed there was no record to review and no documentation of completion of 5, 10, 15-hour medication training, medication clinical skills checklist or previous employment verification.

Telephone interview with Staff C on 08/22/23 at 10:28am revealed:
-She was a medication aide (MA) and assisted the SIC/Owner when she was needed.
-She cooked, administered medications, took residents on outings, and assisted with activities of daily living (ADLs) as needed.
-She worked at the facility a couple of weeks ago, but she did not administer medications.
-She had administered medications when she worked at the facility.
-She did not recall the last time she administered medications, but it was since the beginning of the year.
-She had worked at another facility that the SIC/Owner's family member owned.
-The SIC/Owner had all her paperwork showing she had the required MA training.

Interview with two residents on 08/21/23 at 2:00pm revealed Staff C administered medications to them when she worked.

Interview with the SIC/Owner on 08/21/23 at 4:16pm revealed:
-Staff C did not really do anything at the facility.
-Staff C "just provided supervision to the residents."
-She knew she had to have a personnel record for Staff C but she thought her family member had the record and that was good enough.

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C 131	Continued From page 20 -Staff C did not come to the facility that many times, but she would think about needing to get Staff C's record, and then she would forget. Interview with the Administrator on 08/21/23 at 5:28pm revealed: -She did not know who Staff C was. -She expected the SIC/Owner to let her know when new employees where hired. -All staff should have required testing done prior to working with the residents. -She did not audit personnel records.	C 131		
C 132	10A NCAC 13G. 0403(b) Qualifications Of Medication Staff (b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff (A) who administered medications had the required 6 hours of annual training for medication administration. The findings are: Review of Staff A's personnel record revealed: -She was hired in April 1985.	C 132		

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C 132	Continued From page 21 -She was hired as a medication aide. -There was no documentation of continued education since November 2021 in the record. Interview with Staff A on 08/21/23 at 2:31pm revealed: -She was the Supervisor-in-Charge (SIC)/Owner of the facility. -She did not know the last time she had medication administration training. -The 6 hour medication administration training was offered through the facility's contracted pharmacy. -She would have to call the pharmacy to schedule a medication administration training class. Interview with the Administrator on 08/21/23 at 4:41pm revealed: -The facility's contracted pharmacy did the 6-hour annual medication administration training. -She did not know the last time the SIC/Owner had the 6-hour medication administration training. -She was responsible for ensuring the SIC/Owner received her 6-hour medication administration training. -She did not audit personnel records.	C 132		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by:	C 145		

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C 145	Continued From page 22 TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff (B, C) had no substantial findings listed on the North Carolina Health Care Personnel Registry. The findings are: 1. Review of Staff B's personnel record revealed there was no personnel record to review. Interview with Staff B on 08/21/23 at 2:18pm revealed: -She had been visiting the Supervisor in Charge (SIC)/Owner since the 07/15/23. -She owned a facility that was not in operation at this time. -She would stay with the residents when the SIC/Owner had appointments. -She stayed with the residents when the SIC/Owner would go look for a resident who had walked away from the home. -The HCPR had not been checked since she arrived on 07/15/23. -She did not need the HCPR checked since she had previously owned a facility. Interview with the SIC/Owner on 08/21/23 at 2:18pm revealed: -She did not check the HCPR for Staff B. -Staff B had owned a facility, but it was closed. -Staff B's HCPR was in her personnel record, which was at the facility that was now closed. -She did not think she needed to check the HCPR for Staff B since she previously had one. Interview with the Administrator on 08/21/23 at 5:28pm revealed: -Staff B was a relative of the SIC/Owner.	C 145		

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C 145	Continued From page 23 -Staff B worked as a SIC when she was in the facility. -Staff B had a personnel record from previously owning a facility but she had not brought the personnel record to this facility. -She was responsible for doing the HCPR check on anyone who assisted with the residents. -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. -She cooked, administered medications, took residents on outings, and assisted with activities of daily living (ADLs) as needed. -She worked at the facility a couple of weeks ago. -She did not know what the HCPR was or if hers had been checked. Interview with the SIC/Owner on 08/21/23 at 4:16pm revealed: -Staff C did not really do anything at the facility. -Staff C "just provided supervision to the residents." -She knew she had to have a personnel record for Staff C but she thought her family member had the record and that was good enough. -Staff C did not come to the facility that many times, but she would think about needing to get Staff C's record, and then she would forget. Interview with the Administrator on 08/21/23 at 5:28pm revealed: -She did not know who Staff C was. -She expected the SIC/Owner to let her know when new employees where hired.	C 145		

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C 145	Continued From page 24 -She did not audit personnel records. _____ The facility failed to ensure Staff B and Staff C did not have substantiated findings listed on the Health Care Personnel Registry (HCPR) prior to working at the facility. The facility's failure resulted in it being unknown if staff had substantiated findings on the HCPR, which was detrimental to the health, welfare, and safety of the resident 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 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure 2 or 3 sampled staff (B, C) had a criminal background check completed upon hire. The findings are: 1. Review of Staff B's personnel record revealed there was no personnel record to review.	C 147		

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C 147	Continued From page 25 Interview with Staff B on 08/21/23 at 2:18pm revealed: -She had been visiting the Supervisor in Charge (SIC)/Owner since the 07/15/23. -She had owned a facility that was not in operation at this time. -She would stay with the residents when the SIC/Owner had appointments. -She stayed with the residents when the SIC/Owner would go look for a resident who had walked away from the home. -She had a criminal background check done when she owned a facility. -She did not need to have another criminal background check done since she had one years ago at the other facility. Interview with the SIC/Owner on 08/21/23 at 2:18pm revealed: -She did not do a criminal background check for Staff B. -Staff B had owned a facility, but it was closed. -Staff B's criminal background check was in her personnel record, which was at the other facility that was now closed. -She did not think she needed to check Staff B's criminal background since she previously had one. Interview with the Administrator on 08/21/23 at 5:28pm revealed: -Staff B was a relative of the SIC/Owner. -Staff B worked as a SIC when she was in the facility. -Staff B had a personnel file from previously owning a facility, but she had not brought the personnel record to this facility. -She was responsible for doing the criminal background checks on anyone who assisted with the residents.	C 147		

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C 147	Continued From page 26 -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. -She cooked, administered medications, took residents on outings, and assisted with activities of daily living (ADLs) as needed. -She worked at the facility a couple of weeks ago. -She did not know if a criminal background had been checked. Interview with the SIC/Owner on 08/21/23 at 4:16pm revealed: -Staff C did not really do anything at the facility. -Staff C "just provided supervision to the residents." -She knew she had to have a personnel record for Staff C but she thought her family member had the record and that was good enough. -Staff C did not come to the facility that many times, but she would think about needing to get Staff C's record, and then she would forget. Interview with the Administrator on 08/21/23 at 5:28pm revealed: -She did not know who Staff C was. -She expected the SIC/Owner to let her know when new employees where hired. -She did not audit personnel records. _____ The facility failed to ensure 2 of 3 staff had a criminal background check completed prior to hire. The facility's failure resulted in it being unknown if Staff B and Staff C had a criminal history which was detrimental to the safety and	C 147		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 147	Continued From page 27 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 147		
C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 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 as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B, C) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: 1. Review of Staff B's personnel record revealed there was no personnel record to review. Interview with Staff B on 08/21/23 at 2:18pm revealed: -She had been visiting the Supervisor in Charge (SIC)/Owner since the 07/15/23.	C 148		

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-She had owned a facility that was not in operation at this time.
-She would stay with the residents when the SIC/Owner had appointments.
-She stayed with the residents when the SIC/Owner would go look for a resident who had walked away from the home.
-She had a drug screen done when she owned a facility, but it was now closed.
-She did not need to have another drug screen done since she had one years ago when she owned a facility.

Interview with the SIC/Owner on 08/21/23 at 2:18pm revealed:
-She did not do a drug screen done for Staff B.
-Staff B had owned a facility, but it was closed.
-Staff B's drug screen would be in her personnel record, which was at the facility that was now closed.
-She did not think she needed to do Staff B's drug screen since she previously had one.

Interview with the Administrator on 08/21/23 at 5:28pm revealed:
-Staff B was a relative of the SIC/Owner.
-Staff B worked as a SIC when she was in the facility.
-Staff B had a personnel record from previously owning a facility, but she had not brought the personnel record to this facility.
-She was responsible for ensuring the drug screen was done before Staff B assisted with residents.
-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

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C 148	Continued From page 29 10:28am revealed: -She was a medication aide and assisted the SIC/Owner when she was needed. -She cooked, administered medications, took residents on outings, and assisted with activities of daily living (ADLs) as needed. -She worked at the facility a couple of weeks ago. -She had not had a drug screen since she had started working at this facility. Interview with the SIC/Owner on 08/21/23 at 4:16pm revealed: -Staff C did not really do anything at the facility. -Staff C "just provided supervision to the residents." -She knew she had to have a personnel record for Staff C but she thought her family member had the record and that was good enough. -Staff C did not come to the facility that many times, but she would think about needing to get Staff C's record, and then she would forget. Interview with the Administrator on 08/21/23 at 5:28pm revealed: -She did not know who Staff C was. -She expected the SIC/Owner to let her know when new employees where hired. -She did not audit personnel records. _____ The facility failed to ensure an examination and screening for the presence of controlled substances was performed for 2 of 3 sampled staff (B and C) hired after 10/01/13. This failure was detrimental to the health, safety, and welfare of all 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		

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C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. 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 1985. -She was the Supervisor-in-Charge (SIC)/Owner. -She was hired as a medication aide. -There was a Licensed Health Professional Support (LHPS) tasks competency validation dated 07/15/23. -Staff A had not been validated for vital signs (including blood pressure checks). -The LHPS tasks competency validation had not been signed by the LHPS nurse.	C 171		

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C 171	Continued From page 31 Interview with the Staff A at 08/21/23 at 2:52pm revealed: -She knew how to check a resident's blood pressure. -She had been taking blood pressures for years. -She did not know the LHPS validation form did not assess her ability to check a resident's blood pressure. -She had a friend who owned a business, and her friend came to check her off for her LHPS competency validation. -She was not aware the LHPS validation was different from the medication checklist. Interview with the Administrator on 08/21/23 at 4:41pm revealed: -She thought the Pharmacist from the facility's contracted pharmacy completed the LHPS validation for the facility staff. -She did not think anyone else came to the facility to train the facility staff. -She was not aware the SIC/Owner had not been validated to check blood pressures. -She did not audit the SIC/Owner's personnel record.	C 171		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall	C 185		

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C 185	Continued From page 32 share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules for family care homes related to outside entrances and exits, design and construction, fire safety and disaster plan, medication administration, personal care and supervision, health care, nutrition and food service, medication storage, controlled substances, qualifications of medication staff, other staff qualifications, competency validation for licensed health, resident assessment, licensed health professional support, activities program, resident rights, medication orders, controlled substance and infection prevention and control program. The findings are: Observation of the facility upon arrival on 08/18/23 at 8:05am revealed five residents were residing in the facility. Interview with the Supervisor-in-Charge (SIC)/Owner on 08/18/23 at 4:08pm revealed: -The Administrator came to the facility about every 2 months. -The Administrator stayed about 30-45 minutes. -The Administrator checked to make sure she did	C 185		

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not need anything.
-The Administrator did not go to the residents' rooms.
-The Administrator had not been to the facility since the newest resident moved in into the facility in June 2023.

Telephone interview with the Administrator on 08/18/23 at 4:46pm revealed:
-She had not been to the facility in about a month.
-She went to the facility every "two months or so."
-She usually talked to the SIC/Owner by telephone or video once or twice a week.

Interview with two residents on 08/21/23 at 2:00pm revealed:
-They did not know anyone at the facility by the Administrator's name.
-They thought the SIC/Owner was the Administrator.

Interview with the SIC/Owner on 08/18/23 at 2:12pm and 3:19pm revealed:
-The Administrator was at the facility on 08/19/23.
-She had to show the Administrator how to leave the facility on 08/19/23, because the Administrator got lost trying to find the facility.

Telephone interviews with the Administrator on 08/21/23 at 3:34pm and 4:43pm revealed:
-She thought the facility had door alarms.
-She did not know the alarms had been turned off.
-She was not aware the residents did not exit the facility during fire drills.
-She had not observed any fire drills at the facility.
-She did not audit resident records or personnel records.
-Prior to 08/19/23, the last time she was at the facility someone drove her; she stayed about 1.5

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C 185	Continued From page 34 hours. Non-compliance was identified in the following rule areas: 1. Based on observations and interviews, the facility failed to ensure the residents were not left alone in the facility without supervision of staff. [Refer to Tag 186 10A NCAC 13G. 0601(b) Management and Other Staff. (TYPE A1 VIOLATION)]. 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs, care plan and current symptoms for 2 of 5 sampled residents (#1, #5) related to Resident #1, who had a history of mental illness and was known to wander from the facility and away from the Supervisor-in-Charge (SIC) when on outings, leaving the facility multiple times on 08/18/23 and 08/21/23; and Resident #5, who had a diagnosis of dementia and was reported to have been physically abusive to other residents and was not supervised when she went outside to smoke and was observed lighting cigarettes inside the facility (#5). [Refer to Tag 243 10A NCAC 13G .0901(b) Personal Care And Supervision. (TYPE A1 VIOLATION)]. 3. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, and #3) including an anti-psychotic medication (#1); a diabetic medication used to control blood sugars (#2); and a medication for elevated blood pressure (#3). [Refer to Tag 330 10A NCAC 13G .1004(a) Medication Administration (TYPE A2 VIOLATION)].	C 185		

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C 185	Continued From page 35 4. Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 5 sampled residents (#5) who had a diagnosis of dementia and did not respond to the fire drill. [Refer to Tag 022 10A NCAC 13G .0302(b) Design And Construction (TYPE B VIOLATION)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors accessible to residents, who wandered away from the facility (#1) and a resident who was sometimes disoriented (#5), had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. [Refer to Tag 069 10A NCAC 13G .0312(g) Outside Entrance and Exits (TYPE B VIOLATION)]. 6. Based on record reviews and interviews, the facility failed to ensure that fire evacuation plans were rehearsed at least four times yearly. [Refer to Tag 100 10A NCAC 13G .0316(e) Fire Safety And Disaster Plan (TYPE B VIOLATION)]. 7. Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled staff (B, C) had no substantial findings listed on the North Carolina Health Care Personnel Registry. [Refer to Tag 145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications (TYPE B VIOLATION)]. 8. Based on record reviews and interviews, the facility failed to ensure 2 or 3 sampled staff (B, C) had a criminal background check completed upon hire. [Refer to Tag 147 10A NCAC 13G .0406(a)(7) Other Staff Qualifications (TYPE B	C 185		

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C 185	Continued From page 36 VIOLATION)]. 9. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B, C) had an examination and screening for the presence of controlled substances completed upon hire. [Refer to Tag 148 10A NCAC 13G .0406(a)(8) Other Staff Qualifications (TYPE B VIOLATION)]. 9. Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 4 sampled residents (#5) related to fingernails and toenails that needed to be trimmed. [Refer to Tag 242 10A NCAC 13G .0901(a) Personal Care and Supervision. (TYPE B VIOLATION)]. 10. Based on observations, interviews, and record reviews, the facility failed to refer 1 of 3 sampled residents (#2) who was a diabetic and needed their toenails trimmed, to a podiatrist. [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (TYPE B VIOLATION)]. 11. 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). [Refer to Tag 249 10A NCAC 13G .0902(c)(3-4) Health Care (TYPE B VIOLATION)]. 12. Based on interviews and record reviews, the facility failed to protect two residents (#1, #4) from being hit by another resident and failed to ensure the residents were treated with dignity and	C 185		

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respect related to residents arguing with each other. [Refer to Tag 311 10A NCAC 13G .0909 Resident Rights (TYPE B VIOLATION)].

13. Based on observations, record reviews, and interviews, the facility failed to ensure there were readily retrievable records for controlled substances by documenting the receipt, administration, and disposition for 1 of 1 sampled resident (#1) with an order for a medication used to treat anxiety. [Refer to Tag 367 10A NCAC 13G .1008(a) Controlled Substances (TYPE B VIOLATION)].

14. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (B, C) who administered medications, completed a medication clinical skills checklist and had documentation they had successfully passed the written state medication administration examination, and completed the 5, 10, or 15-hour medication aide (MA) training course or had verification of previous as a MA before administering medication to residents. [Refer to Tag 131 10A NCAC 13G .0403(a) Qualifications of Medication Staff (Standard Deficiency)].

15. Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff (A) who administered medications had the required 6 hours of annual training for medication administration. [Refer to Tag 132 10A NCAC 13G .0403(b) Qualifications of Medication Staff (Standard Deficiency)].

16. 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

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checks. [Refer to Tag 171 10A NCAC 13G .0504(a) Competency Validation for Licensed Health (Standard Deficiency)].

17. Based on record reviews, and interviews, the facility failed to ensure that an initial assessment was completed within 72 hours of admission using the Resident Register for 3 of 3 sampled residents (#1, #2, and #3). [Refer to Tag 230 10A NCAC 13G .0801(a) Resident Assessment (Standard Deficiency)].

18. Based on interviews and record reviews, the facility failed to ensure a care plan was completed within 30 days of admission for 2 of 3 sampled residents (#2, #3). [Refer to Tag 231 10A NCAC 13G .0801(b) Resident Assessment (Standard Deficiency)].

19. Based on observations, record reviews, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed within 30 days from the date a resident developed the need for the task for 1 of 3 sampled residents (#1) with a LHPS task of fingerstick blood sugar (FSBS) monitoring. [Refer to Tag 254 10A NCAC 13G .0903(c)Licensed Health Professional Support (Standard Deficiency)].

20. Based on interviews and record reviews, the facility failed to ensure menus for therapeutic diets were planned and/or reviewed by a licensed dietician for 1 of 1 sampled resident (#2) who had an order for an HHCC diet. [Refer to Tag 270 10A NCAC 13G .0904(c)(7) Nutrition and Food Service (Standard Deficiency)].

21. Based on observations, record reviews, and interviews the facility failed to offer snacks to the

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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)].

24. Based on record reviews, observations, and interviews, the facility failed to ensure activities were provided to promote the residents' involvement and engaged the residents who resided in the facility. [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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C 185	Continued From page 40 26. Based on record reviews and interviews, the facility failed to contact the Primary Care Provider (PCP) for 2 of 3 sampled residents (#1, #3) for clarification of orders for an anti-psychotic (#1) and a stool softener (#3). [Refer to Tag 315 10A NCAC 13G .1002(a) Medication Orders (Standard Deficiency)]. 27. Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #3) including a medication for involuntary movements (#1); and a diuretic, a hormone replacement medication, an anxiety medication, a blood pressure medication, medication for depression, and two medications for reflux (#3). [Refer to Tag 342 10A NCAC 13G .1004(j)Medication Orders (Standard Deficiency)]. 28. Based on observation, record review, and interviews, the facility failed to ensure medications for 1 of 5 residents (#3) were stored in a locked container. [Refer to Tag 353 10A NCAC 13G .1006(b) Medication Storage (Standard Deficiency)]. 29. Based on observations and interviews the facility failed to ensure controlled medication, including an anti-anxiety medication, was stored under a double lock. [Refer to Tag 368 10A NCAC 13G .1008(b) Controlled Substances (Standard Deficiency)]. 30. Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled staff (A), who administered medications, completed the state-mandated infection control training annually. [Refer to Tag 613 10A NCAC 13G .1701(d) Infection Prevention and Control Program (Standard Deficiency)].	C 185		

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C 185	Continued From page 41 The Administrator failed to ensure the overall management, operations, and policies of the facility were implemented by failing to ensure a resident (#1), who wandered and was adjudicated incompetent, leaving the facility unsupervised on multiple occasions without staff knowing her whereabouts; resident (#5) fighting and arguing without staff present in the facility or intervening; outside entrances and exits had alarms that activated and sounded when opened to alert staff that a resident had left the facility (#1) and a resident who was disoriented had exited the facility (#5); fire drills were performed so the residents would know how to evacuate in the event of a fire; medications were administered as ordered to a resident whose antipsychotic medication had not been discontinued after having increased hallucinations, a resident who was diabetic had not received his medication to lower his blood sugars and another resident had not received his blood pressure medication (#1,#2, and #3); had 13 tablets of a controlled medication unaccounted for; and the implementation of LHPS tasks for two residents including blood pressure (#2) and fingerstick blood sugar checks (#1). This failure of the Administrator resulted in serious neglect of the residents which constitutes a Type A1 Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 08/21/23. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023.	C 185		
C 186	10A NCAC 13G .0601 (b)(1) Management And Other Staff	C 186		

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C 186	Continued From page 42 10A NCAC 13G .0601 Management And Other Staff (b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used: (1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home; This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the facility failed to ensure the residents were not left alone in the facility without supervision of staff. The findings are: Observations of the facility on 08/18/23 revealed: -At 9:19am, the Supervisor-in-Charge	C 186		

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C 186	Continued From page 43 (SIC)/Owner came into the facility from her private residence to provide the breakfast meal to the residents and returned to her private residence and shut the adjoining door, leaving the residents alone. -At 9:34am, the SIC returned to the facility to administer medications. Observation of the facility on 08/18/23 revealed: -At 2:12pm, the residents entered the SIC/Owner's private residence, picked up their lunch plates, and returned to the dining room in the facility. -There was no staff present with the residents. Observation of the residents' living quarters on 08/18/23 at 3:25pm revealed: -Two residents were seated in the residents' living room. -One resident walked through the kitchenette to the closed door connecting the residents' living quarters to the SIC/Owner's house. -The resident knocked on the door and requested a cigarette from the SIC/Owner. -The SIC/Owner provided the resident with a cigarette and closed the door to the SIC//Owner's house. -The resident walked back to the living room and asked another resident for a light. -The other resident took his lighter and lit the resident's cigarette while she stood in the living room. Observation of the facility on 08/21/23 at 8:13am revealed: -There was a resident sitting in the living room alone. -There was no facility staff in the facility and the door to the SIC/Owner's private residence was closed.	C 186		

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C 186	Continued From page 44 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 medications. -If 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 closed. -The only time the SIC/Owner was in the facility was at breakfast, lunch, and dinner. Interview with a resident on 08/21/23 at 8:24am revealed: -She did not see anyone staying in the facility over the weekend, just "us", the residents. -The SIC/Owner stayed in her house, which was connected to the facility. Interviews with a second resident on 08/21/23 at 9:35am and 4:25pm revealed: -The SIC/Owner's family member stayed in the facility on 08/19/23 but did not stay any other night. -No one else stayed in the facility on Friday, 08/18/23, or Sunday, 08/20/23, but the residents. -The last time he saw the SIC/Owner each night was between 8:00pm and 9:00pm. Interview with a third resident on 08/21/23 at 12:15pm revealed:	C 186		

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C 186	Continued From page 45 -He got up every night over the weekend (08/18/23-08/20/23). -When he got up, the only people he saw in the facility were two other residents. -He did not see anyone in the living room area of the facility when he went outside during the night. Interview with a fourth resident on 08/21/23 at 2:00pm revealed on 08/21/23, between 12:00am and 2:00pm, he went down the hallway and looked in the living room and there were two residents in the living room, but no staff member. Interview with the SIC/Owner on 08/18/23 at 2:12pm and 3:16pm revealed: -She was not in the facility 24/7. -She was in the facility for about an hour each afternoon to clean. -She was not in the facility every morning to wake the residents up for breakfast. -She was in the facility about every 30-45 minutes. -All the residents in her facility were independent. -She was in the facility all the time in the morning and 1 to 2 hours in the afternoon. -She could not be around the residents when they smoked. -When she was not in the facility, she would go over and check on the residents every 30 to 45 minutes during the day and the evening hours. Telephone interview with the Administrator on 08/18/23 at 5:40pm revealed staff would provide supervision to the residents at all times, awake and in the facilty, until an alarm system could be put in place. Telephone interview with the Administrator on 08/21/23 at 3:34pm and 4:43pm revealed: -She thought staff was going to be in the resident	C 186		

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C 186	Continued From page 46 area of the facility 24/7 or close by. -The staff member could be in the private residence as long as the door was open to the facilty and the staff could periodically chick on the residents Refer to Tag 0069, 10A NCAC 13G .0312 Outside Entrance and Exits (Type B Violation). Refer to Tag 243, 10A NCAC 13G .0901(b) Personal Care and Supervision (Type A1 Violation). Refer to Tag 311, 10A NCAC 13G .0909 Resident Rights (Type B Violation). _____ The Administrator and/or Supervisor-in-Charge failed to ensure a staff member was in the facilty at all times to provide supervision to the residents and to ensure the required duties of the facility were implemented, resulting in a resident wandering from the facility on multiple occasions without staff's knowledge and arguing and fighting amongst the residents. This failure resulted in serious neglect of the residents, which constitutes a Type A1 Violation. _____ A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023. A Plan of Protection was not obtained.	C 186		
C 230	10A NCAC 13G .0801(a) Resident Assessment 10A NCAC 13G .0801 Resident Assessment (a) A family care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.	C 230		

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C 230	Continued From page 47 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure that an initial assessment was completed within 72 hours of admission using the Resident Register for 3 of 3 sampled residents (#1, #2, and #3). 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. Review of Resident #1's Resident Register revealed: -Resident #1 was admitted on 05/11/21. -Resident #1's Resident Register had "guardian" checked but there was no name or phone number listed for the guardian. -Resident #1's personal information had been checked, then whited out, with stray marks of ink still visible. -Resident #1's Resident Register was not signed by her guardian. Interview with the Supervisor-in-Charge (SIC)/Owner on 08/21/23 at 2:31pm revealed: -She did not know Resident #1's Resident Register was not signed. -She was responsible for completing and signing the Resident Register. Refer to the telephone interview with the Administrator on 08/21/23 at 4:41pm. 2. Review of Resident #2's current FL-2 dated 05/19/23 revealed diagnoses included schizoaffective bipolar type, schizoaffective	C 230		

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C 230	Continued From page 48 personality disorder, and anxiety disorder. Review of Resident #2's Resident Register revealed there was no resident register available to be reviewed. Review of discharge papers from an inpatient regional psychiatric hospital revealed Resident #2 was discharged to the facility on 05/22/23. Interview with the SIC/Owner on 08/21/23 at 2:12pm revealed: -She was responsible for completing and signing the Resident Register. -Resident #2 was his own responsible party and she thought the resident had signed the Resident Register. Refer to the telephone interview with the Administrator on 08/21/23 at 4:41pm. 3. Review of Resident #3's current FL-2 dated 06/07/23 revealed diagnoses included bipolar disorder, schizophrenia, and post-traumatic syndrome disorder. Review of Resident #3's Resident Register revealed: -Resident #3 was admitted on 06/07/23. -Resident #1's Resident Register had "guardian" checked with the name and telephone number of his guardian. -Resident #1's Resident Register was not signed by his guardian or the Administrator. Interview with the SIC/Owner on 08/21/23 at 2:31pm revealed: -Resident #3's guardian was not from the local Department of Social Services. -The Administrator sent Resident #3's Resident	C 230		

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C 230	Continued From page 49 Register to his guardian for signature. -Resident #3's guardian sent the Resident Register back unsigned. -She had not followed-up to see why the Resident Register was not signed. Refer to the telephone interview with the Administrator on 08/21/23 at 4:41pm. Interview with the Administrator on 08/21/23 at 4:41pm revealed: -The Resident Register should be completed and signed within 72 hours. -The SIC/Owner and the Administrator were responsible for having the Resident Register completed and signed within 72 hours. -She did not routinely do record audits; she may have done an audit 3 to 4 months ago.	C 230		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The	C 231		

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C 231	Continued From page 50 assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a care plan was completed within 30 days of admission for 2 of 3 sampled residents (#2, #3). 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 disorder. Review of discharge papers from an inpatient regional psychiatric hospital revealed Resident #2 was discharged to the facility on 05/22/23. Review of Resident #2's care plan revealed: -The care plan had been completed but was not dated with an assessment date. -The care plan was not signed by the Supervisor in Charge (SIC)/Owner. -The care plan was not signed by Resident #2's Primary Care Provider (PCP). Interview with the SIC/Owner on 08/21/23 at 2:12pm revealed: -She was responsible for completing Resident #2's care plan. -She forgot to take Resident #2's care plan to the PCP on his last visit.	C 231		

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C 231	Continued From page 51 Refer to the telephone interview with the Administrator on 08/21/23 at 4:41pm. 2. Review of Resident #3's current FL-2 dated 06/07/23 revealed diagnoses included bipolar disorder, schizophrenia, and post-traumatic syndrome disorder. Review of Resident #3's care plan revealed there was no care plan to review. Interview with the SIC/Owner on 08/21/23 at 2:31pm revealed: -Resident #3 was independent and cared for himself. -She was responsible for completing the care plans for Resident #3. -She did not remember doing a care plan for Resident #3. Refer to the telephone interview with the Administrator on 08/21/23 at 4:41pm. _____ Telephone interview with the Administrator on 08/21/23 at 4:41pm revealed: -The SIC/Owner was responsible for completing the care plan and having the PCP sign it within 30 days. -The SIC/Owner would take the care plan to the PCP for signature with she took the resident for a visit. -She had not audited the resident records and did not know there was an issue with care plans for the residents.	C 231		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and	C 242		

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C 242	Continued From page 52 Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care for 1 of 4 sampled residents (#5) related to fingernails and toenails that needed to be trimmed. The findings are: Review of Resident #5's current FL-2 dated 11/07/22 revealed diagnoses included dementia without behavioral disturbance, hypertension, and hyperlipidemia. Review of Resident #5's Care Plan dated 11/07/22 revealed: -Resident #5 was sometimes disoriented. -Resident #5 had significant memory loss and must be directed. Observation of Resident #5's toenails on 08/18/23 at 11:07am revealed: -The first toenail on her left foot was broken in multiple places in the nail bed. -The toenail on her second toe extended past the end of the toe and was broken. -The toenails on her third and fourth toes extended past the end of the toe one-fourth of an inch and were turning toward the opposite toe. -The toenail on the fifth toe was broken and jagged, leaving a sharp edge.	C 242		

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C 242	Continued From page 53 -The first toenail on her right foot was broken and jagged. -The toenails on all other toes extended past the end of the toe one-fourth of an inch and they were thick and pointed. Observation of Resident #5's fingernails on 08/21/23 at 8:26am revealed: -Her fingernails extended past the end of her fingers three-quarters of an inch. -The fingernails on her thumbs were broken and jagged. -All of her fingernails had a buildup of grime and dirt underneath each nail. Interview with Resident #5 on 08/18/23 at 11:10am revealed: -She could not cut her nails. -It had been a while since anyone had cut her nails, toenails, or fingernails. Telephone interview with Resident #5's legal guardian on 08/21/23 at 8:45am revealed: -She saw Resident #5 at the facility on 07/17/23. -Resident #5 had a diagnosis of dementia. -She expected the facility staff to make sure daily care including assistance with hygiene and showers was done. -She would expect the facility staff to take care of Resident #5's toenails and fingernails during showers and personal care. -She had spoken to the Supervisor in Charge (SIC)/Owner on 07/17/23 about Resident #5's toenails and fingernails needing to be trimmed. -The SIC/Owner responded that Resident #5 cut her nails, but they would assist her. -She was concerned Resident #5's toenails and fingernails had still not been cut because it was a safety concern. -Resident #5 could cut herself or she could also	C 242		

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TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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experience an ingrown toenail which could cause discomfort.
-Resident #5's fingernails also needed to be cleaned for hygienic reasons.

Telephone interview with Resident #5's Primary Care Provider's (PCP) nurse on 08/21/23 at 12:33pm revealed:
-She would expect the facility staff to cut Resident #5's toenails and fingernails.
-Resident #2 could accidentally scratch herself or possibly scratch someone else, which could then get infected.
-If Resident #2's toenails were not cut the resident could experience pain and discomfort with walking.

Interview with the SIC/Owner on 08/21/23 at 2:12pm revealed:
-If a resident was not a diabetic, the resident cut their own toenails and fingernails.
-If the resident needed clippers, the resident could ask her for the clippers.
-Resident #5 could not cut her toenails.
-Resident #5 said she was going to cut her fingernails.
-She recalled Resident #5's legal guardian had mentioned the resident's nails needed to be cut.
-Resident #5's nails were thick, and she needed to order something to cut her nails with.
-The clippers she ordered to cut Resident #5's toenails had "just been delivered."

Interview with the Administrator on 08/21/23 at 4:43pm revealed:
-She had not seen Resident #5's toenails or fingernails.
-If Resident #5's toenails were thick, the resident would need to be taken to a podiatrist.
-When Resident #5 was assisted with her

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C 242	Continued From page 55 shower, the resident's fingernails should be clipped and kept clean. _____ The facility failed to ensure a resident who had a diagnosis of dementia and was sometimes be disoriented with significant memory loss (#5), received the assistance she needed trimming her toenails and fingernails, which resulted in the resident having long, jagged toenails and fingernails, which put the resident an increased risk of injury. This failure was detrimental to the resident's health, safety and welfare 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 242		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs, care plan and current symptoms for 2 of 5 sampled residents (#1, #5) related to Resident #1, who had a history of mental illness and was known to wander from the facility and away from the Supervisor-in-Charge (SIC) when on outings,	C 243		

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C 243	Continued From page 56 leaving the facility multiple times on 08/18/23 and 08/21/23; and Resident #5, who had a diagnosis of dementia and was reported to have been physically abusive to other residents and was not supervised when she went outside to smoke and was observed lighting cigarettes inside the facility (#5). The findings are: 1. Review of the facility's resident contract dated 05/11/23 revealed: -The facility's resident contract was not signed by Resident #1, her legal guardian, or the Administrator. -Services and accommodations included supervision of the residents on a 24-hour basis. -The policy on confused and wandering residents included any resident who desired to leave the facility must sign out and inform two staff witnesses of the location visiting and expected time of return. -Wandering off the facility was prohibited without proper sign-out. -Any wandering off from the facility would show the resident was unable to adjust to the home rules regarding respect for the rights of others. -The facility was not a locked door facility; although precautions had been taken to help ensure the residents did not wander from the facility, but the possibility remained that someone could, without notice. 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. -Resident #1 was ambulatory.	C 243		

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C 243	Continued From page 57 -There were no behaviors noted. Review of Resident #1's Resident Register revealed: -There was an admission date of 05/11/21. -Resident #1 had a guardian. Review of Resident #1's legal documents revealed the court adjudicated Resident #1 incompetent and appointed the county Department of Social Services (DSS) as the guardian for Resident #1 on 12/03/21. Review of Resident #1's care plan dated 11/29/22 revealed: -Resident #1 had a history of mental illness. -Resident #1 received medication for mental illness. -Resident #1 was seen by Mental Health (MH). -There were no behaviors noted. Review of Resident #1's record on 08/18/23 revealed there were no incident/accident reports or staff notes to review. Review of Resident #1's MH Provider's visit note dated 03/27/23 revealed: -The Supervisor-in-Charge (SIC)/Owner reported Resident #1 had been more irritable the past week related to paranoid delusion. -Resident #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	C 243		

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C 243	Continued From page 58 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. -Resident #1 was not doing well due to group home situation. -MH Provider was reluctant to increase selective serotonin reuptake inhibitors (SSRI) (anti-depressants used to treat persistent or severe depression) due to history of worsening psychosis on SSRI medications. Review of a law enforcement report dated 06/23/22 revealed: -The law enforcement agency received a call at 4:40pm from the SIC/Owner regarding Resident #1 who had wandered off while shopping in an adjacent county. -The SIC/Owner reported Resident #1 left the store to go outside and smoke and never returned; Resident #1 had been missing for 45 minutes. -The SIC/Owner reported Resident #1 lived in a home where she could be taken care of, and Resident #1 needed medications for diabetes, blood pressure, and schizophrenia. -Numerous officers responded to the scene but were unable to locate Resident #1. -A missing person form was completed, and the state police were notified. -At 7:30pm, an officer went to the facility and verified Resident #1 had returned home. Review of a second law enforcement report dated 07/09/22 revealed: -The law enforcement received a call at 7:30pm regarding a female on the side of the road flagging down vehicles.	C 243		

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C 243	Continued From page 59 -The dispatcher was told by the caller the female said her great nephew was in danger of being raped by someone she lived with. -The law enforcement located the female and identified her as Resident #1. -Resident #1 stated her mother brought her a wagon to pull behind while she walked, and she was waiting on the wagon to arrive, and her great nephew was in danger of being raped. -Resident #1 stated she heard people talking about "it" while she was lying in bed. -Resident #1 identified the address where she lived. -The deputy returned Resident #1 to the facility. -The deputy spoke to the SIC/Owner who stated Resident #1 was diagnosed with schizophrenia and had episodes where she thought her family was in danger. -The deputy informed the SIC/Owner of the statements Resident #1 had made and the SIC/Owner confirmed she was the only one living upstairs. -The SIC/Owner stated Resident #1 heard voices and the Administrator had called the law enforcement agency before. Review of a third law enforcement report dated 03/06/23 revealed: -A call was received from the SIC/Owner at 3:42pm who reported Resident #1 had walked off from the facility. -A second call received from the SIC/Owner at 3:48pm revealed Resident #1 had returned to the facility. Review of a fourth law enforcement report dated 04/11/23 revealed: -A call was received from the SIC/Owner at 7:06pm who reported Resident #1 had walked off from the facility.	C 243		

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C 243	Continued From page 60 -A second call received from the SIC/Owner at 7:08pm revealed Resident #1 had returned to the facility. Review of a fifth law enforcement report dated 07/01/23 revealed: -A call was received from the SIC/Owner at 10:44pm who reported Resident #1 had walked off from the facility. -A second call received from the SIC/Owner at 10:59pm revealed Resident #1 had returned to the facility. Review of a sixth law enforcement report dated 08/18/23 revealed: -The law enforcement agency received a call at 12:24pm from the SIC/Owner that Resident #1 had "walked off". -The SIC/Owner reported Resident #1 walked toward the mailbox looking for a lizard and had been missing about one hour. -Resident #1 returned to the facility on her own; she stated she had gone fishing. -There was no time documented on the law enforcement report of Resident #1's return. Observations of the facility on 08/18/23 between 8:00am and 10:06am revealed: -Loud voices could be heard from Resident #1's room; Resident #1 was in her room alone. -Resident #1 was in the facility in her bedroom or the living room. Observation on 08/18/23 at 12:52pm revealed the SIC/Owner left the facility on the van to look for Resident #1. Observation on 08/18/23 at 1:15pm revealed the SIC/Owner returned to the facility without Resident #1.	C 243		

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C 243	Continued From page 61 Interview with the SIC/Owner's family member on 08/18/23 at 11:54am revealed Resident #1 must have walked to the mailbox. Interviews with the SIC/Owner on 08/18/23 at 12:52pm, 2:16pm, and 2:43pm revealed: -She left about 11:00am to go to the store to pick up some items. -She did not see Resident #1 when she left the facility to go to the store. -When she returned, 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. -She was going to look for Resident #1. -Resident #1 had not walked away from the facility before and been gone this long. -Resident #1 would walk to the mailbox and maybe a ½ mile to a mile down the road. -She had to pick Resident #1 up once when she was about ½ mile down the road. -Resident #1 has been gone before about 30 minutes but never this long. -Resident #1 would walk to the mailbox daily at 2:00pm. -Resident #1 had never walked off where she had to call the law enforcement agency. -She called the law enforcement agency today, 08/18/23, around 1:00pm because Resident #1 had been gone for 2 to 3 hours. Interview with a resident on 08/18/23 at 2:26pm revealed: -Resident #1 had left the facility walking before. -Resident #1 would be gone for "a while" and then come back. -The SIC/Owner had to go and pick Resident #1 up when Resident #1 did not come back home.	C 243		

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C 243	Continued From page 62 -She did not know how many times the SIC/Owner had to go pick Resident #1 up after Resident #1 had walked away from the facility. Interview with Resident #1 on 08/21/23 at 8:17am revealed: -She walked down the street last Friday, 08/18/23. -She was just walking; she was not walking anywhere special. -She did not go walking "very often" but Friday was not the first time she had walked away from the facility. -She came back home around 7:30 that evening. Interview with a second resident on 08/21/23 at 8:24am revealed: -Resident #1 walked off when they went on outings. -Resident #1 was seen getting in a vehicle with three males but they did not leave the parking lot. -The SIC/Owner was in a store when this occurred, and the residents were in the parking lot waiting for the SIC/Owner. -Resident #1 asked people for money when they were on outings, and it was embarrassing. -Resident #1 had left the facility before and was gone all day but never overnight. Interview with a third resident on 08/18/23 at 2:28pm and 4:25pm revealed: -Resident #1 walked away from the facility 4 to 5 days a week. -Resident #1 would come back on her own "most days." -The SIC/Owner had to go and pick Resident #1 up on the van "sometimes". -He did not think the local law enforment had picked Resident #1 up and brought her back to the facility.	C 243		

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C 243	Continued From page 63 Interview with the SIC/Owner on 08/18/23 at 3:16pm revealed: -Resident #1 liked to panhandle when she went on outings. -Resident #1 would give strangers the facility's address and phone number. -Resident #1 would talk to herself. -Today Resident #1 was talking about a little girl who came into her room and stole a lizard out of her pocketbook. -Resident #1 needed the most supervision because she would walk away from the facility. Telephone interview with the Administrator on 08/18/23 at 4:46pm revealed she had talked to the SIC/Owner earlier today, around 12:30pm but she was not told Resident #1 had walked away from the facility. Telephone interview with the Adult Home Specialist (AHS) at the local Department of Social Services on 08/21/23 at 1:40pm revealed: -She was notified by her supervisor on Friday, 08/18/23, Resident #1 had wandered from the facility. -The SIC/Owner did not notify DSS Resident #1 had walked away from the facility on 08/18/23. -The SIC/Owner had never notified DSS Resident #1 had wandered from the facility. -The SIC/Owner informed her on Friday, 08/18/23, Resident #1 had walked away when they were shopping on 06/23/22, and she had to wait 2 hours before Resident #1 returned. -Resident #1 begged people for money when Resident #1 was out in the community. -She arrived at the facility on Saturday, 08/19/23 at 10:10am; there was one resident sitting outside the door. -When she entered the facility living quarters	C 243		

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there were no residents and no staff in the living room.
-The SIC/Owner was on her side of the house with the door closed; there was one resident sitting outside and four residents in their rooms.

Telephone interview with the Administrator on 08/18/23 at 5:00pm revealed:
-The SIC/Owner had not informed her Resident #1 wandered from the facility.
-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.

Review of a voicemail received from the Administrator on 08/18/23 at 7:25pm revealed Resident #1 had returned to the facility and the resident was "ok."

Observation of the facility on 08/21/23 between 8:00am and 9:30am revealed Resident #1 was in the facility in her bedroom or living room.

Observation of the SIC/Owner on 08/21/23 at 9:55am revealed she got in the van and left the facility.

Observation of the SIC/Owner on 08/21/23 at 10:05am revealed she returned to the facility alone.

Interview with the SIC/Owner on 08/21/23 at 10:24am revealed:
-She left the facility to go and pick up Resident #1 who had walked away from the facility.
-Resident #1 had walked to the end of the driveway and about ½ mile down the road.
-Resident #1 said she was going to get her

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C 243	Continued From page 65 pocketbook. -She was headed back to the pond where she said she was on Friday, 08/18/23. -Resident #1 was paranoid about her pocketbook and people stealing from her; "she even slept with it." Interview with the SIC/Owner on 08/21/23 at 2:12pm revealed: -Resident #1 went outside to smoke cigarettes; it would take a few minutes. -If Resident #1 was outside longer than a few minutes, she would walk off. -She could see through the kitchen window when the resident left the facility through the back door. -Today, 08/21/23, she asked her family member where Resident #1 was, and the family member responded Resident #1 was outside smoking. -When she looked outside and did not see Resident #1 smoking, but saw the resident's shoes, she thought the resident had left so she went looking for her. Observation on 08/21/23 at 1:50pm revealed: -Resident #1 walked out of the exit door of the residents' living quarters and headed toward the driveway. -At 1:53pm, the SIC/Owner's family member walked out the exit door of the residents' living quarters and looked down the driveway and turned and walked in the opposite direction, calling for Resident #1. -At 1:57pm, the SIC/Owner got in the van and drove down the driveway and returned in 2 minutes. Observation on 08/21/23 at 1:59pm revealed Resident #1 walked back into the yard and into the house.	C 243		

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C 243	Continued From page 66 Interview with the SIC/Owner on 08/21/23 at 2:00pm revealed: -She drove down the driveway to see if Resident #1 had walked to the mailbox. -Resident #1 was walking back toward the house when she saw her. -Resident #1 told the SIC/Owner she had walked to the mailbox. -She reminded Resident #1 that she could not go to the mailbox alone. Interview with the SIC/Owner's family member on 08/21/23 at 2:10pm revealed: -She saw Resident #1 walk out the living room door. -She went to the door and looked but did not see Resident #1. -Another resident was sitting outside and when asked if he saw Resident #1, he stated she walked in the opposite direction of the driveway. -She walked fast and got away. Interview with Resident #1 on 08/21/23 at 2:15pm revealed: -She went to the mailbox to get the mail. -She did not tell anyone she was going to the mailbox. -She was walking back toward the house when the SIC/Owner came on the van to get her. -She did not get in the van; she walked back to the house. Observation on 08/21/23 at 3:36pm revealed Resident #1 was walking on the driveway toward the house with mail in her hand. Interview with Resident #1 on 08/21/23 at 3:42pm revealed: -She walked to the mailbox (0.3 mile from the house).	C 243		

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C 243	Continued From page 67 -She went out the back door of the residents' living quarters. -She did not tell anyone she was going to the mailbox. Interviews with the SIC/Owner's family member on 08/21/23 at 3:37pm and 3:44pm revealed: -She thought Resident #1 was in her room. -She was in the residents' living quarters in the living room; she did not see Resident #1 walk past her. -She must have dozed off and Resident #1 walked past her. -She would have heard Resident #1 if she had gone out the back door. -She did not know Resident #1 went out the back door. Observation of the SIC/Owner's family member on 08/21/23 at 3:46pm revealed she re-positioned her chair so she could see both exit doors. Telephone interview with a nurse at Resident #1's Primary Care Provider's (PCP) office on 08/21/23 at 12:22pm revealed: -The PCP's office was not notified Resident #1 walked away from the facility on 08/18/23 and was gone for 9 hours. -There was no documentation Resident #1 had ever walked away from the facility. -The PCP would have wanted to know each time Resident #1 walked away from the facility. -Resident #1 could have had problems with her blood sugar because Resident #1's medications may not have been administered as scheduled. -Resident #1 needed her medications for her schizophrenia so she would not become disoriented and start hallucinating. Interviews with the SIC/Owner on 08/21/23 at	C 243		

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	FCL017018	A. BUILDING: _____ B. WING _____	08/21/2023

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C 243	Continued From page 68 10:32am, 2:12pm, 3:47pm revealed: -She notified Resident #1's legal guardian who was at a DSS in another county on 08/18/23 regarding Resident #1 walked away from the facility. -She did not think to call the local DSS to let them know Resident #1 had walked away from the facility. -She did not know she was supposed to call the local DSS when a resident was known to be missing from the facility. -Resident #1 would walk to the mailbox daily. -She knew Resident #1 walked out the back door; she heard the door open and close. -She could see Resident #1 walk through the backyard to the driveway when she was in the kitchen. -Resident #1 would get the mail and come back to the facility. -She did not hear the back door open or close and she did not see Resident #1 leave the facility for the third time on 08/21/23. -Her family member had been staying in the facility to supervise the residents on third shift since Friday, 08/18/23. -First and second shift was being covered by herself and her family member. -She did not know why the residents said they did not see her family member in the facility, because "she was out there." -The SIC/Owner's family member may have come into the private residence to ask a question, and out of habit shut the door behind her. -Her family member came into the private residence to use the bathroom, wash up and change clothes. -Her family member was in the private residence helping get breakfast ready, but Resident #1 was in the bed asleep. -Resident #1 usually went back to bed after	C 243		

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C 243	Continued From page 69 breakfast and that was when her family member would get washed up and dressed. -She would check on Resident #1 every 5 minutes when her family member was not in the residents' living quarters, but once Resident #1 was "up" someone stayed in the facility all the time. -Resident #1 was slick and had slipped by even though the family member was in the facility providing supervision. -She was concerned because it was dangerous for Resident #1 to walk away and something could happen to her. -She had called the police before when Resident #1 walked off but before the police even got there Resident #1 had returned so she did not do an incident report. -Resident #1 had walked off "8-9 times this year" but 08/18/23 was the only time she could not find the resident. -Resident #1 would usually be back within an hour. Interviews with the Administrator on 08/21/23 at 11:39am, 3:48pm and 4:47pm revealed: -She did not know Resident #1 was walking away and leaving the facility. -She did not know Resident #1 had walked away from the facility today, 08/21/23. -The SIC/Owner had to keep someone in the residents' living quarters to watch Resident #1. -If Resident #1 walked outside someone would have to go outside with her. -She knew Resident #1 would walk to the mailbox but thought Resident #1 always returned to the facility. -She did not know Resident #1 had walked to the mailbox and continued 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.	C 243		

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C 243	Continued From page 70 -The facility staff needed to go outside with Resident #1 each time she went outside. -The facility staff needed to pay more attention to the residents to ensure they did not walk away and go to the road. Attempted interview with Resident #1's Mental Health Provider on 08/21/23 at 10:17am was unsuccessful. Attempted interview with Resident #1's legal guardian on 08/21/23 at 2:00pm was unsuccessful.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. 2. Review of Resident #5's current FL-2 dated 11/07/22 revealed diagnoses included dementia without behavioral disturbance, hypertension, and hyperlipidemia. Review of Resident #5's Resident Register revealed Resident #5 had a legal guardian. Review of Resident #5's legal documents revealed the resident was adjudicated incompetent and the county Department of Social Services (DSS) was approved guardian for Resident #5 on 12/03/21. Review of Resident #5's Care Plan dated 11/07/22 revealed: -Resident #5 was sometimes disoriented. -Resident #5 had significant memory loss and must be directed.	C 243		

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C 243	Continued From page 71 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 said she would take care of it. -He heard 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 had hit her, but it had been a while so she could not recall any specific details. -Resident #5 argued with others. -She had never hit Resident #5.	C 243		

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C 243	Continued From page 72 -She knew the SIC/Owner did not do anything about Resident #5 arguing/hitting because Resident #5 was still arguing with her. Interview with Resident #5 on 08/18/23 at 11:49am revealed: -She had never hit another resident. -She and her roommate argued, and her roommate hit her, but she had never hit another resident. Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -Resident #5 had a diagnosis of dementia. -She could tell Resident #5 something and two minutes later the resident would not remember. -Resident #5 "tended to hit others." -When she talked to Resident #5 about hitting other residents, Resident #5 denied hitting anyone. -She had not witnessed Resident #5 argue or hit other residents; she was only told that it occurred. -She 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 dementia. -She expected the facility staff to provide supervision of Resident #5 to ensure her safety. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -She was not aware some residents were arguing in the facility. -She was not aware Resident #5 had hit another resident. -She would have expected the SIC/Owner to let her know as she could have talked to Resident #5 and could have intervened. -She would not want a resident to get hurt.	C 243		

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C 243	Continued From page 73 Attempted telephone interview with Resident #5's Mental Health (MH) Provider on 08/21/23 at 10:05am was unsuccessful. 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 smoked. -Smoking 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 safety. -The 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. Observation of Resident #5 on 08/18/23 at various times from 8:00am-3:00pm revealed: -Resident #5 went in and out of the facility to smoke. -There was no staff present in the facility when Resident #5 went in and out of the facility. -Multiple times Resident #5 would ask another resident for their cigarette lighter, and she would light her cigarette in the living room and walk	C 243		

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C 243	Continued From page 74 outside. Observation of the residents' living quarters on 08/18/23 at 3:25pm revealed: -Resident #5 and another resident were seated in the residents' living room. -Resident #5 walked through the kitchenette to the closed door connecting the residents' living quarters to the SIC/Owner's house. -Resident #5 knocked on the door and requested a cigarette from the SIC/Owner. -The SIC/Owner provided Resident #5 with a cigarette and closed the door to the SIC//Owner's house. -Resident #5 walked back to the living room and asked another resident for a light. -The other residents took his lighter and lit Resident #5's cigarette while Resident #5 stood in the living room. -Resident #5 walked outside once her cigarette was lit. Observation of the residents' living quarters on 08/18/23 at 4:45pm revealed: -Resident #5 was in the living room with a cigarette in her hand. -Resident #5 approached another resident in the living room and asked the resident to light her cigarette. -The other resident took his lighter and lit Resident #5's cigarette while Resident #5 stood in the living room. -Resident #5 walked outside once her cigarette was lit. Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -Resident #5 was not allowed to have a cigarette lighter because she and another resident had been lighting cigarettes inside the facility.	C 243		

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C 243	Continued From page 75 -She did not know Resident #5 had lit cigarettes multiple times inside the facility, today, 08/18/23. Interview with Resident #5 on 08/21/23 at 12:20pm revealed: -She did not know why she did not have a lighter. -She thought she lost her lighter. -She had never smoked inside. -She borrowed a lighter from another resident to light her cigarette and went "straight outside." Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed she expected any resident with a diagnosis of dementia to be supervised, and watched more closely, for the resident's safety. Attempted telephone interview with Resident #5's Mental Health (MH) Provider on 08/21/23 at 10:05am was unsuccessful. 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. _____ Interview with a resident on 08/21/23 at 9:35am revealed: -The SIC/Owner's family member stayed in the facility on 08/19/23 but did not stay any other night. -No one else stayed in the facility on Friday, 08/18/23, or Sunday, 08/20/23, but the residents. Interview with another resident on 08/21/23 at 2:00pm revealed on 08/21/23 sometime between	C 243		

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C 243	Continued From page 76 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. Interview with the SIC/Owner on 08/18/23 at 2:12pm revealed: -She was not in the facility 24/7. -She was in the facility for about an hour each afternoon to clean. -She was not in the facility every morning to wake the residents up for breakfast. -She was in the facility about every 30-45 minutes. 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 facility. -She thought staff was going to be in the resident area of the facility 24/7 or close by. -The 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 residents. -Residents were expected to be supervised closer to ensure they were in the facility. _____ The facility's failure to provide supervision for two residents resulted in a resident, who had a history of mental illness and diabetes, leaving the facility unsupervised on 08/18/23 for more than 9 hours and on 08/21/23 for 3 times and her whereabouts were unknown each time (#1); and a resident, who had a diagnosis of dementia and was sometimes disoriented, had hit other residents and was not allowed to have a lighter because she had a history of lighting cigarettes inside the facility but was observed lighting cigarettes inside	C 243		

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C 243	Continued From page 77 the facility while no staff was present (#5). This failure resulted in serious neglect of the residents and constitutes a Type A1 Violation. _____ 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 243		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to refer 1 of 3 sampled residents (#2), who was a diabetic and needed their toenails trimmed, to a podiatrist. The findings are: Review of Resident #2's current FL-2 dated 05/19/23 revealed diagnoses included schizoaffective bipolar type, schizoaffective personality disorder, and anxiety disorder. 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.	C 246		

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C 246	Continued From page 78 Interview with Resident #2 on 08/18/23 at 11:59am revealed: -His toenails needed to be cut. -He did not recall the last time his toenails had been cut. -His toenails were so long they had cut open the end of his sock. Observation of Resident #2's toenails on 08/18/23 at 11:59am revealed: -Resident #2's first toenail on his right foot protruded through the end of his sock. -All the cuticles around the toenails on the right and left feet were dry and cracked. -The first toenail on his right foot was extended past the end of the toe by one-eighth of an inch. -The second toenail on his right foot curled over the end of the toe and was broken and jagged. -The toenails on the third, fourth, and fifth toes of the left and right feet curled over the end of the toes. -The first toenail on his left foot was broken and jagged. -The second toenail on his left foot extended one-half an inch past the end of the toe and was growing toward the first toe. Telephone interview with Resident #2's PCP's nurse on 08/21/23 at 2:50pm revealed: -Resident #2 would need to see a podiatrist for nail care because he was a diabetic. -If Resident #2's toenails were long, the resident could snag the toenail, which could pull the toenail off, which could then get infected, and was then at risk of amputation if the infection did not heal. According to the American Diabetic Association toenails should be trimmed because long or thick	C 246		

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C 246	Continued From page 79 nails could press on neighboring toes and cause open sores. Toenails should be cut straight across because cutting into the corners of a nail could cause ingrown toenails. An emery board should be used to file down any sharp edges. Interview with the Supervisor in Charge (SIC)/Owner on 08/21/23 at 2:12pm revealed: -She could not cut Resident #2's toenails because he was a diabetic. -She had not seen Resident #2's toenails because he was usually always dressed. -She had not asked Resident #2 if his toenails needed to be cut or asked to see his toenails. -She would make an appointment for Resident #2 to see a podiatrist. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -She had not seen Resident #2's toenails -She did not know Resident #2's toenails needed to be trimmed. -Resident #2 needed to be seen by a Podiatrist. -She expected the SIC/Owner to make an appointment for Resident #2 to be seen by a Podiatrist. -If Resident #2's toenails were not kept trimmed the resident could experience an ingrown toenail and get an infection. _____ The facility failed to ensure a resident, who had diabetes and needed his toenails trimmed, was referred to a podiatrist, which resulted in the resident having long, jagged toenails (#2) which put the resident an increased risk of injury. This failure was detrimental to the health, safety and welfare of the resident, and constitutes a Type B Violation. _____ A SUMMARY SUSPENSION OF LICENSE WAS	C 246		

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C 246	Continued From page 80 ISSUED ON AUGUST 23, 2023. A Plan of Protection was not obtained.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. 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 disorder. -There was an order to check the resident's blood pressure (BP) twice daily and as needed (prn).	C 249		

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	FCL017018	A. BUILDING: _____ 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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 249	Continued From page 81 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. Review of Resident #2's medication administration records (MAR) for June 2023, July 2023, and August 2023 from 08/01/23-08/21/23 revealed the only documentation for a BP for Resident #2 was on 08/20/23 with a reading of 103/79; there was no time documented. 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 2:57am. -On 07/14/23, Resident #2's BP was documented as 132/80 at 9:02am. -On 07/16/23, Resident #2's BP was documented as 126/67 at 5:17pm and 101/72 at 5:33pm. -On 08/20/23. Resident #2's BP was documented as 157/99 at 10:34am and 142/90 at 10:47am. Telephone interview with Resident #2's PCP's nurse on 08/21/23 at 2:50pm revealed: -Resident #2 had a diagnosis of hypertension. -Resident #2 was taking two different medications for elevated BP and was at risk for his BP dropping too low. -It was important to monitor Resident #2's BP since he was taking the two BP medications. Interview with Resident #2 on 08/18/23 at 4:20pm revealed: -No one at the facility had checked his BP. -He did not know if anyone at the facility should check his BP or not. -He had times he felt lightheaded, but he did not recall when.	C 249		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 249	Continued From page 82 Observation of Resident #2's blood pressure on 08/21/23 at 5:28pm revealed: -The Supervisor-in-Charge (SIC)/Owner took Resident #3's BP. -His BP reading was 137/93. Interview with the SIC/Owner on 08/21/23 at 5:28pm revealed: -The SIC/Owner's family member had taken Resident #2's BP recently; she could not remember the day. -Resident #2's BP was not checked this morning. -She was checking Resident #2's BP now because the surveyor asked her too. Interview with the SIC/Owner on 08/21/23 at 2:12pm revealed: -She did not know Resident #2 had an order to check his BP. -After she was asked if any of the residents had an order to check their BPs on 08/18/23, she looked at the residents' records and saw Resident #2 had an order for BP checks, but the order did not say how often. -She did not recall what Resident #2's BP order was. -While reviewing Resident #2's FL-2, she stated she did not see the BP order. -When the order for Resident #2's BP was shown to her, she read the order as B10 and PRE. -When she was told it was ordered as BID (twice a day) and PRN (as needed) she stated "Yes, I remember that now," Resident #2's BP was supposed to be checked twice a day. -She had her family member check Resident #2's BP yesterday, 08/20/23, in the morning but Resident #2's BP was not checked a second time. -She did not know Resident #2 had an order to	C 249		

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check his BP until 08/18/23, because "she had overlooked it."
-She forgot to check Resident #2's BP on Saturday, 08/19/23, and Resident #2 went to the hospital on Sunday, 08/20/23, so she only checked his BP once.
-Resident #2 returned from the hospital on 08/20/23, "a little after 3:00pm."

Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed:
-She expected the SIC/Owner to review the FL-2 so she would know what to do for Resident #2.
-She expected the SIC/Owner to check Resident #2's BP twice daily as ordered and to document the results.

2. Review of Resident #1's current FL-2 dated 11/29/22 revealed a diagnosis of diabetes mellitus type 2.

Review of Resident #1's physician's order dated 06/27/23 revealed there was an order for fingerstick blood sugar (FSBS) monitoring once a week or if the resident became sick.

Review of Resident #1's June 2023 medication administration record (MAR) from 06/28/23 to 06/30/23, July 2023 MAR, and August 2023 MAR from 08/01/23 to 08/18/23 revealed there was no entry for FSBS checks weekly.

Observation of the Supervisor-in-Charge (SIC)/Owner during the 8:00am morning medication pass on 08/21/23 revealed:
-The SIC gathered supplies for a FSBS check.
-The SIC checked Resident #1's FSBS with a reading of 134.

Observation of Resident #1's glucometer

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revealed:
-There was 1 FSBS reading of 134 on 08/21/23 at 8:48pm.
-There 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 morning.
-She 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 checks.
-Resident #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.)

Interview with the SIC/Owner on 08/21/23 at 8:43am revealed:
-There was an order to monitor Resident #1's FSBS reading weekly.
-She had checked Resident #1's FSBS 5 to 6 times since it was ordered in June 2023.
-She used the same glucometer with each FSBS check.
-She did not know why the readings from June 2023 and July 2023 were not in the glucometer.
-There were a few weeks she did not check Resident #1's FSBS because Resident #1 would eat breakfast before she checked it.

Telephone interview with the Administrator on 08/21/23 at 4:41pm revealed:

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C 249	Continued From page 85 -The SIC/Owner should fax the FSBS order to the pharmacy so it could be entered on the MAR. -The SIC/Owner should document the FSBS reading each time it was checked. -If the SIC/Owner did not check Resident #1's FSBS reading, she should document a reason why it was not checked. -She did not audit the residents' records for new orders. _____ 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 was not obtained.	C 249		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission	C 254		

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C 254	Continued From page 86 or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed within 30 days from the date a resident developed the need for the task for 1 of 3 sampled residents (#1) with a LHPS task of fingerstick blood sugar (FSBS) monitoring. The findings are: Review of Resident #1's current FL-2 dated 11/29/22 revealed a diagnosis of diabetes mellitus type 2. Review of Resident #1's physician's order dated 06/27/23 revealed there was an order for fingerstick blood sugar (FSBS) monitoring once a week or if the resident became sick. Review of Resident #1's record revealed there was no LHPS assessment completed since Resident #1 received an order for weekly FSBS	C 254		

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C 254	Continued From page 87 checks on 06/27/23. Observation of Resident #1's glucometer revealed: -There was 1 FSBS reading of 134 on 08/21/23 at 8:48pm. -There 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 morning. -She did not know her FSBS was to be checked weekly. Interview with the Supervisor-in-Charge (SIC)/Owner on 08/21/23 at 2:31pm revealed: -She did not have anyone to do LHPS assessments. -She thought the Pharmacist did the LHPS assessments. -She did not know the requirements for LHPS assessments. -She did not know Resident #1 needed to have an LHPS assessment with 30 days of the FSBS order and quarterly, thereafter. Interview with the Administrator on 08/21/23 at 4:41pm revealed: -She did not know who did the facility's LHPS assessments. -She thought the pharmacy did the LHPS assessments. -The LHPS assessments should be done within 30 days of a task being ordered. -The SIC/Owner and the Administrator were responsible for ensuring the LHPS assessment were completed when needed. -She did not audit residents' records.	C 254		

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C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure menus for therapeutic diets were planned and/or reviewed by a licensed dietician for 1 of 1 sampled residents (#2) who had an order for an HHCC diet. The findings are: 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 a diet order for HHCC (there was no explanation of what this diet was). Review of Resident #2's Primary Care Provider's (PCP) after-visit summary dated 08/03/23 revealed: -Resident #2 also had diagnoses to include hyperlipidemia, diabetes mellitus, and hypertension. -There was documentation the PCP talked with Resident #2 about the importance of controlling their lipid condition towards reducing cardiovascular risk.	C 270		

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C 270	Continued From page 89 -The importance of diet and nutrition, the restriction of simple sugars, saturated fats, deep 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. Observation of the facility's menu revealed: -There were menus for a regular diet, a no-added salt diet, a no-concentrated sweets diet, and a low fat/low cholesterol diet. -The menus were not signed by a Registered Dietitian. -There was no menu for an HHCC diet. Interview with Resident #2 on 08/18/23 at 2:37pm revealed: -He did not know if he was on a special diet or not, but he tried to eat healthy. -All the residents were served the same meal. -He got a different cereal in the morning, but other meals were the same. -He skipped meals at the facility because the meal was too greasy or too salty for him. Telephone interview with Resident #2's PCP's nurse on 08/21/23 at 2:50pm revealed she was not sure what diet had been ordered for Resident #2, but the PCP had documented talking to Resident #2 about the importance of nutrition. Interview with the SIC/Owner on 08/21/23 at 2:12pm revealed: -Resident #2's FL-2 had his diet listed as regular. -She did not know what HHCC stood for that was listed on Resident #2's FL-2. -She had not seen HHCC listed on Resident #2's	C 270		

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C 270	Continued From page 90 FL-2; she thought regular was listed as the diet. -She did not have a menu for HHCC. -The Administrator had provided her with menus for the facility. Telephone interview with the Administrator on 04/21/23 at 4:43pm revealed: -She did not know what an HHCC diet was. -The SIC/Owner should have contacted the resident's PCP to ask about a diet order. -If the SIC/Owner did not have a menu for the diet ordered by the PCP, the SIC/Owner could have told the PCP what diets were available to see if one of the diets offered by the facility would meet the resident's needs and obtain a corrected diet order.	C 270		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to offer snacks to the residents three times a day. The finding are:	C 272		

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C 272	Continued From page 91 Review of the facility's menu revealed snacks were not listed on the menu. Observation on 08/18/23 and 08/21/23 at various times between 9:00am and 5:00pm revealed there were no snacks offered to the residents. Observation of snacks provided to the surveyor by the Supervisor in Charge (SIC)/Owner on 08/21/23 at 1:53pm revealed she had a box of granola bars, fruit snacks, and popcorn. Interview with a resident on 08/18/23 at 2:26pm revealed: -She would get a snack if she asked for one. -She received a cookie yesterday. Interview with another resident on 08/18/23 at 2:28pm revealed: -He had not had any snacks today, 08/18/23. -He received a snack at night, between 8:00pm and 9:00pm. -The snacks were fruit snacks, granola bars, or popcorn. -He did not receive a snack in the morning or the afternoon. -Snacks were not available during the day. Interview with a third resident on 08/18/23 at 2:36pm revealed: -He only received a snack when he asked for one. -The only snacks available were fruit snacks, granola bars, or popcorn. -They had the same 3 snacks all the time. -Snacks were not offered three times a day. Interview with a fourth resident on 08/18/23 at 2:37pm revealed:	C 272		

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C 272	Continued From page 92 -He sometimes got hungry during the day. -If he wanted a snack he had to go to the SIC/Owner's door and knock to ask for a snack. -Sometimes the SIC/Owner would get upset because she was busy and he was told to come back later. Interview with a fifth resident on 08/21/23 at 9:19am revealed they had to ask the SIC/Owner for snacks. Interview with the SIC/Owner on 08/21/23 at 3:12pm revealed: -Sometimes she forgot to put snacks out for the residents. -The residents knocked on the door when they wanted a snack. -The residents usually asked for snacks twice a day, but sometimes they would ask three times per day. -Sometimes she would ask the residents if they wanted a snack. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -Snacks should be provided to the residents at least three times per day. -The residents should not have to ask the SIC/Owner for a snack; the snacks should have been offered.	C 272		
C 283	10A NCAC 13G .0904 (e)(3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Therapeutic Diets in Family Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	C 283		

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C 283	Continued From page 93	C 283		

This Rule is not met as evidenced by:
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 residents with an order for an HHCC diet (#2).

The findings are:

Observation of the kitchen during the initial tour on 08/18/23 revealed there was no diet listing of residents with therapeutic diets available for reference.

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 a diet order for HHCC (there was no explanation of what this diet was).

Review of Resident #2's Primary Care Provider's (PCP) after-visit summary dated 08/03/23 revealed:
-Resident #2 also had diagnoses to include hyperlipidemia, diabetes mellitus, and hypertension.
-There was documentation the PCP talked with Resident #2 about the importance of controlling their lipid condition towards reducing cardiovascular risk.
-The importance of diet and nutrition, the restriction of simple sugars, saturated fats, deep

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TAYLOR FAMILY CARE HOME #2	1136 BERTHA WILSON ROAD 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 283	Continued From page 94 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. Interview with the SIC/Owner's family member on 08/21/23 at 10:08am revealed: -She stayed with the residents recently when the SIC/Owner had an overnight hospital stay on 07/30/23. -She did not have to prepare meals because the SIC/Owner had prepared the meals before she left the facility and returned to the facility before breakfast was served the next day. -All the residents were on regular diets. Interview with the SIC/Owner on 08/21/23 at 3:12pm revealed: -She did not have a diet list to use as guidance for meal preparation. -No other staff had prepared meals for the residents, and she knew what to prepare so she did not need a diet list. Telephone interview with a medication aide (MA) on 08/22/23 at 10:28am revealed: -She assisted the SIC/Owner when she was needed. -She cooked, administered medications, took residents on outings, and assisted with activities of daily living (ADLs) as needed. -She worked at the facility a couple of weeks ago; she did not recall the date. -She worked an 8-hour shift and prepared both breakfast and lunch on the day she worked. -She prepared whatever was on the menu for the day she worked.	C 283		

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C 283	Continued From page 95 -All the residents were served the same meal. -She had not seen a diet list but thought a female resident who had diabetes was on a special diet. -She probably used less sodium and sweeteners the day she prepared meals. Telephone interview with the Administrator on 04/21/23 at 4:43pm revealed: -She expected the SIC/Owner to have a diet list posted to use for meals and snacks. -She was concerned if someone else was preparing the residents' meals, they would not know what the residents could have or not have.	C 283		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, 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. The findings are: Review of Resident #2's current FL-2 dated 05/19/23 revealed: -Diagnoses included schizoaffective bipolar type, schizoaffective personality disorder, and anxiety	C 284		

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C 284	Continued From page 96	C 284		

disorder.
-There was an order for a [named] nutritional supplement used for people with diabetes.

Review of Resident #2's Primary Care Provider's (PCP) after-visit summary dated 08/03/23 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:
-Resident #2 was served two cups of whole grain cereal with milk; he ate 100% of his meal.
-The other residents were served a different type of cereal.

Observation of the cereals available to the residents on 08/18/23 at 9:21am revealed there was one large box of a peanut butter and chocolate flavored pre-sweetened cereal.

Interview with the Supervisor in Charge (SIC)/Owner on 08/18/23 at 9:21am revealed she did not have any of the whole grain cereal because she had used it all today, 08/18/23.

Interview with Resident #2 on 08/18/23 at 2:37pm revealed:
-Sometimes he missed more than one meal in a day.
-He had not been offered or provided a nutritional supplement when he skipped a meal.

Observation of the breakfast meal service on 08/21/23 at 8:55am revealed:
-The residents were eating bowls of cereal.
-Resident #2 was drinking a cup of coffee and juice.
-Resident #2 did not have any cereal or any other

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C 284	Continued From page 97 food items. Interview with Resident #2 on 08/21/23 at 9:40am revealed: -The facility did not have a cereal he wanted to eat today, 08/21/23. -He did not like the cereal the other residents were eating. -He was not offered any other food items for breakfast. Interview with the Supervisor in Charge (SIC)/Owner on 08/21/23 at 2:12pm revealed: -Resident #2 always ate his meals. -She knew Resident #2 ate his meals because she would go into the facility before the residents finished eating. -She was not aware Resident #2 did not always eat his meals unless it was when he did not like what she had prepared. -There were times when Resident #2 did not like what she had prepared for the dinner meal; she did not have an alternate menu to choose from. -She had offered Resident #2 something different to eat but he did not want what she offered. -She did not recall when Resident #2 did not want to eat what she offered but Resident #2 did not miss meals a lot. -She did not know what the [named] supplement was, and she did not have a nutritional supplement to provide to Resident #2. -She did not see an order for the nutritional supplement for Resident #2. Observation of the SIC/Owner on 08/21/23 at 3:10pm revealed she located a magnifying glass to look at Resident #2's FL-2. Second interview with the SIC/Owner on 08/21/23 at 3:12pm revealed:	C 284		

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C 284	Continued From page 98 -She could see the order for the [named] supplement. -She asked if the order meant for Resident #2 to have the nutritional supplement if the resident missed one meal or missed eating all day. Telephone interview with Resident #2's Primary Care Provider's (PCP) nurse on 08/21/23 at 2:50pm revealed if Resident #2 was not eating a meal, his blood sugar could drop, and he would need the supplement for nutrition. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -The [named] supplement was a nutritional supplement used for people with diabetes. -She did not know Resident #2 had an order for the nutritional supplement to be served if the resident ate less than fifty percent. -She would have expected the SIC/Owner to have contacted Resident #2's PCP to obtain a prescription for the supplement so she could obtain the supplement. -She was concerned Resident #2's blood sugar could drop if he was not eating and had not been provided the supplement as a meal replacement.	C 284		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure activities were provided to promote the residents'	C 288		

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C 288	Continued From page 99 involvement and engaged the residents who resided in the facility. The findings are: Review of the August 2023 activities calendar revealed: -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. -Every Sunday praise and worship was listed; there was no start or stop time. -Every Saturday, cleaning and wash day was listed; there was no start or stop time. -Every Monday, mall/dollar store were listed; there was no start or stop time. -Other activities listed included, movie night, word search puzzles, listen to music, pizza party, exercise, catch ball, and checkers; there were no start or stop times listed. -The activity listed for 08/18/23 was movie night and 08/21/23 was listed as mall/dollar store (no times were listed). Observation of the residents on 08/18/23 and 08/21/23 at various times from 8:00am-5:00pm revealed: -One resident only came out of his room to eat meals. -Four residents sat in their rooms, in the living room, or outside on the porch. -There were no activities offered to the residents. Interview with a resident on 08/18/23 at 8:10am revealed: -There were no activities for the residents to do; he slept, ate, and was bored. -He went out with the SIC/Owner and the other residents 1 to 2 times a week.	C 288		

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C 288	Continued From page 100 -They went to the grocery store and a few other stores. Interview with another resident on 08/21/23 at 9:19am revealed: -The residents did not have activities at the facility. -All she did was walk. Interview with a third resident on 08/21/23 at 8:24am revealed: -They never had activities at the facility, "nothing at all." -They never had group activities. -She would participate in activities if they were offered. Interview with the SIC/Owner on 08/21/23 at 2:12pm revealed: -Activities at the facility "basically" were going on outings three times per week. -She took the residents riding, shopping, and out to lunch. -The residents did not participate in games. -One time she promised a resident she would play checkers with her, but she "never got to it." -There were cards at the facility for the residents to play if they wanted to. -There were magazines available for the residents to look at. -The residents got exercise when they went out the door. -Cleaning and wash day was when the residents "got their clothes together, straightened their closets and such." -Praise and worship were listed as an activity because the residents could watch it on television, but they had not; "she did not want to push it on anyone." -A resident wanted to go to church but the other	C 288		

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C 288	Continued From page 101 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 provided. -She did not consider cleaning and wash day an activity; they probably could have worded that a different way. -The SIC/Owner could have listed things like going to the library or riding. -She had not asked the residents if they had been offered activities. -She 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 288		
C 301	10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services 10A NCAC 13G .0906 Other Resident Services (f) Visiting. (1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator; (2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home; (3) A signout register must be maintained for	C 301		

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C 301	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 illness. -Resident #1 received medication for mental illness. -Resident #1 was seen by Mental Health (MH).	C 301		

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Review of a report from a local law enforcement agency dated 08/18/23 revealed:
-The law enforcement agency received a call at 12:24pm from the Supervisor in Charge (SIC)/Owner that Resident #1 had "walked off".
-The SIC/Owner reported Resident #1 walked toward the mailbox looking for a lizard and had been missing about one hour: last known secure time was 12:24pm.
-Resident #1 returned to the facility on her own; she stated she had gone fishing.
-There was no time documented on the law enforcement report of Resident #1's return.

Interview with the Adult Home Specialist (AHS) at the Department of Social Services (DSS) on 08/21/23 at 1:40pm revealed:
-She was notified by her supervisor on Friday, 08/18/23, Resident #1 had wandered from the facility.
-The SIC/Owner did not notify DSS Resident #1 had walked away from the facility on 08/18/23.
-The SIC/Owner had never notified DSS Resident #1 had wandered from the facility.
-The SIC/Owner informed her on Friday, 08/18/23, Resident #1 had walked away once when shopping, and the SIC/Owner had to wait 2 hours before Resident #1 returned.

Interview with the SIC/Owner on 08/21/23 at 10:24am revealed:
-She did not call the local DSS.
-She did not know she needed to call the local DSS.
-She had called Resident #1's legal guardian, who worked at the neighboring county DSS.
-She thought notifying Resident #1's legal guardian was the only DSS she needed to notify.

Interview with the Administrator on 08/21/23 at

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C 301	Continued From page 104 4:41pm revealed: -The SIC/Owner should notify the local DSS when a resident walked away and was missing. -She expected the SIC/Owner to notify the local DSS anytime there was a resident missing. -The SIC/Owner notified the DSS in the adjoining county because that was where Resident #1's legal guardian worked. -It was the responsibility of the SIC/Owner to notify the local DSS.	C 301		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to protect two residents (#1, #4) from being hit by another resident and failed to ensure the residents were treated with dignity and respect related to residents arguing with each other. The findings are: 1. a. Review of Resident #4's current FL-2 dated 10/27/22 revealed diagnoses included mental health disorder, attention-deficit/hyperactivity disorder (ADHD), and intellectual developmental disability. Interview with Resident #4 on 08/18/23 at 11:34am revealed:	C 311		

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C 311	Continued From page 105 -A female resident had hit him twice, once while he was in the living room and once when he was in the laundry room. -The Supervisor-in-charge (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 the female resident had hit him and the SIC/Owner said she would take care of it. -He heard the SIC/Owner tell the female resident not to hit other residents. -The SIC/Owner did the same thing when the female resident hit him a second time. -He had heard the female resident argue with other residents but did not know if the female resident had hit any other residents. Interview with the female resident on 08/18/23 at 11:49am revealed she had never hit another resident. Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm. b. 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. Interview with Resident #1 on 08/21/23 at 9:19am revealed: -A female resident got on her nerves. -A female resident hit her, but it had been a while so she could not recall any specific details. Interview with the female resident on 08/18/23 at 11:49am revealed: -She had never hit another resident. -She and Resident #1 argued, and Resident #1	C 311		

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C 311	Continued From page 106 hit her, but she had never hit another resident. -Resident #1 was overbearing and hateful. -Resident #1's behavior upset her. -She had told the SIC/Owner. Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm. _____ Interview with the medical assistant at the female resident's Mental Health (MH) Provider on 08/21/23 at 10:05am revealed: -The resident had a diagnosis of unspecified dementia without behavioral disturbances. -The MH Provider had not been notified about the resident hitting others in the facility. -She would expect the facility to notify the MH Provider because the resident's medication may need adjusting. Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -A female resident "tended to hit others." -She had not witnessed the female resident hit other residents; she was only told that it occurred. -When she talked to the female resident about hitting other residents, the female resident denied hitting anyone. -She did not recall when the incidents occurred. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed she was not aware residents had hit each other. Refer to the telephone interview with the Administrator on 08/21/23 at 4:43pm. 2. Interview with a resident on 08/18/23 at 11:34am revealed two female residents were always arguing.	C 311		

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C 311	Continued From page 107 Interview with a second resident on 08/18/23 at 11:49am revealed: -She and her roommate argued. -Her roommate was overbearing and hateful. -Her roommate's behavior upset her. Interview with a third resident on 08/21/23 at 9:19am revealed: -Her roommate got on her nerves. -Her roommate argued with others. -She knew the SIC/Owner did not do anything about the resident's arguing because the resident was still arguing with her. Interview with a fourth resident on 08/21/23 at 11:39am revealed: -Two residents and the SIC/Owner argued. -He wished the arguing and fighting would stop. Interview with the SIC/Owner on 08/18/23 at 3:00pm revealed: -She had heard arguing in her private residence and had to go into the facility to check on the residents. -She had had to raise her voice at a resident before. -Another resident told her he did not like listening to the arguing; she did not recall when but the resident had only been at the facility since June 2023. Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed: -She was not aware residents were arguing. -It was not fair to the other residents to have to listen to the arguing as it could get on the residents' nerves and make the residents nervous and scared. Refer to the telephone interview with the	C 311		

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C 311	Continued From page 108 Administrator on 08/21/23 at 4:43pm. _____ Telephone interview with the Administrator on 08/21/23 at 4:43pm revealed it was her responsibility to make sure the residents were safe and treated fairly. _____ 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 SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023. A Plan of Protection was not obtained.	C 311		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.	C 315		

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C 315	Continued From page 109 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to contact the Primary Care Provider (PCP) for 2 of 3 sampled residents (#1, #3) for clarification of orders for an anti-psychotic (#1) and a stool softener (#3). 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. Review of Resident #1's July 2023 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 07/01/23 to 07/31/23. Review of Resident #1's August 2023 MAR from 08/01/23 to 08/17/23 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	C 315		

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C 315	Continued From page 110 tablets were administered at bedtime from 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. Interview with Resident #1 on 08/21/23 at 8:24am revealed: -She had been taking 6 tablets of a medication for a very long time; she did not know the name of the medication. -She did not remember the doctor changing the medication to one tablet. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed: -The pharmacy had an order for clozapine 100mg 6 tablets at bedtime dated 07/17/23. -The pharmacy received the original order for clozapine 100mg 6 tablets at bedtime on 05/28/21. -The pharmacy did not receive an order for clozapine 100mg at bedtime in November 2022. -The pharmacy did not receive Resident #1's FL-2 dated 11/29/22. -If the pharmacy had received Resident #1's FL-2 dated 11/29/22, they would have clarified the clozapine order with the Primary Care Provider (PCP). Telephone interview with the nurse at the PCP's office on 08/21/23 at 12:22pm revealed: -Resident #1 had an order for clozapine 100mg 6 tablets at bedtime. -The FL-2 was completed by the staff at the PCP's office. -Clozapine 100mg was the correct medication	C 315		

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and strength but the incorrect dosage was entered on the FL-2.

Interview with the Supervisor-in-Charge (SIC)/Owner on 08/21/23 at 10:10am revealed:
-Resident #1 had taken clozapine 100mg 6 tablets for years.
-When she received Resident #1's FL-2 she filed the FL-2 in Resident #1's record.
-She did not complete 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 order on the current FL-2 was different from what Resident #1 was being administered.
-She did not give copies of the FL-2 to the pharmacy.
-She should have compared the FL-2 with the MAR and called the PCP and pharmacy for clarification.

Refer to the telephone interview with the Administrator on 08/21/23 at 3:48pm.

2. Review of Resident #3's current FL-2 dated 06/07/23 revealed:
-Diagnoses included bipolar, schizophrenia, and post-traumatic stress disorder.
-There was no order for docusate sodium 100mg (a stool softener) daily

Review of Resident #3's hospital discharge summary dated 06/07/23 revealed there was an order for docusate sodium 100mg daily.

Review of Resident #3's June 2023 medication administration record (MAR) from 06/08/23 to 06/30/23 revealed:
-There was an entry for docusate sodium 100mg

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daily with a scheduled administration time of 8:00pm.
-There was documentation docusate sodium was administered from 06/08/23 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.

Interview with Resident #3 on 08/21/23 at 2:15pm revealed:
-He knew he had an order for a stool softener.
-He was taking stool softeners before he came to the facility.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed:
-The pharmacy had an order for docusate sodium 100mg daily dated 06/07/23.
-The pharmacy received the discharge summary from the hospital.
-The pharmacy did not receive Resident #3's FL-2 dated 06/07/23.

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C 315	Continued From page 113 -If the pharmacy had received Resident #3's FL-2 dated 06/07/23, they would have clarified whether Resident #3 was to continue with docusate sodium or to discontinue the medication since the discharge summary and the FL-2 was dated the same date. Interview with the Supervisor-in-Charge (SIC)/Owner on 08/21/23 at 10:10am revealed: -Resident #3 had been taking docusate sodium since he was admitted to the facility. -When she received Resident #3's FL-2, she filed the FL-2 in Resident #3's record. -Resident #3 was admitted with a FL-2 and a hospital discharge summary. -The hospital discharge summary was taken to the pharmacy. -She did not compare the FL-2 dated 06/07/23 with the hospital discharge summary dated 06/07/23. -She did not know docusate sodium was ordered on the hospital discharge summary and not on the FL-2. -She should have compared the FL-2 with the hospital discharge summary and called the PCP for clarification. Attempted telephone interview with Resident #3's Primary Care Provider (PCP) on 08/21/22 at 10:05am was unsuccessful. Refer to the telephone interview with the Administrator on 08/21/23 at 3:48pm. _____ Telephone interview with the Administrator on 08/21/23 at 3:48pm revealed: -The SIC/Owner should compare the FL-2 with the MAR each time a new FL-2 was completed and signed by the PCP. -The SIC/Owner should make sure that the FL-2	C 315		

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C 315	Continued From page 114 and the MAR matched. -If the FL-2 and the MAR did not match, the SIC/Owner should call the PCP to clarify the order. :	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, and #3) including an anti-psychotic medication (#1); a diabetic medication used to control blood sugars (#2); and a medication for elevated blood pressure (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 11/29/22 revealed: -Diagnosis included undifferentiated	C 330		

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schizophrenia.
-There was an order for escitalopram 10mg (an antipsychotic medication used to treat 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 receiving.
-Symptoms of serotonin syndrome included mental status changes, hallucinations, anxiety, and delirium.

Review of Resident #1's June 2023 medication administration record (MAR) revealed:
-There was an entry for escitalopram 10mg one tablet daily with a scheduled administration time of 8:00am.
-There was documentation escitalopram 10mg was administered daily from 06/07/23 to 06/30/23.

Review of Resident #1's July 2023 MAR revealed:
-There was an entry for escitalopram 10mg one tablet daily with a scheduled administration time of 8:00am.
There was documentation escitalopram was administered daily from 07/01/23 to 07/31/23.

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C 330	Continued From page 116 Review of Resident #1's August 2023 MAR from 08/01/23 to 08/18/23 revealed: -There was an entry for escitalopram 10mg one tablet daily with a scheduled administration time of 8:00am. -There was an entry for escitalopram 10mg was administered daily from 08/01/23 to 08/17/23. Observation of Resident #1's medication on hand on 08/18/23 at 10:49am revealed there was a box with multi-dose packs of medication with a label that 30 escitalopram 10mg tablets were dispensed on 07/17/23. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed: -The pharmacy had an order for escitalopram 10mg daily for Resident #1. -The pharmacy dispensed 30 escitalopram 10mg tablets on 03/21/23, 04/16/23, 05/15/23, 06/15/23, and 07/17/23. -The pharmacy did not receive an order to discontinue escitalopram 10mg daily in March 2023. -The pharmacy would not have dispensed escitalopram 10mg if a discontinued order had been received in the pharmacy. -The pharmacy received faxed orders from the facility or the physician's office; sometimes the facility staff would hand deliver the prescription. -When a medication was discontinued, the pharmacy staff would pick up the monthly multi-dose package of medication, return to the pharmacy, remove the discontinued medication from the multi-dose pack, repackage the medications for the remainder of the month and return the medication to the facility. Review of Resident #1's MH Provider's visit note	C 330		

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C 330	Continued From page 117 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. -Resident #1 was not doing well due to group home situation. -MH Provider was reluctant to increase selective serotonin reuptake inhibitors (SSRI) (anti-depressants used to treat persistent or severe depression) due to her history of worsening psychosis on SSRI medications. Observation of the facility on 08/18/23 between 8:00am and 10:06am revealed loud arguing could be heard from Resident #1's room; Resident #1 was in her room alone. Interview with the Supervisor in Charge (SIC)/Owner on 08/18/23 at 3:00pm revealed: -Resident #1 "heard things", she heard people talking that were not there. -Today, 08/18/23, Resident #1 stated a little girl took a lizard out of her pocketbook. -Resident #1 stated no one had a right to steal from her. Second interview with the SIC/Owner on 08/18/23 at 3:44:pm revealed: -She knew Resident #1's escitalopram was discontinued in March 2023. -She took Resident #1 to the MH Provider and	C 330		

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was told to discontinue the medication.
-The MH provider's office faxed new orders to the pharmacy.
-The pharmacy staff would pick up the multi-dose packs, take them to the pharmacy, repackage the medication without the discontinued medication and return the multi-dose packs to the facility.
-She did not remember if the pharmacy picked up the multi-dose packs in March 2023 to remove the discontinued medication and repackage the remainder of the medications.
-If the medication was in the multi-dose pack, she administered the medication.
-She started signing the June 2023, July 2023, and August 2023 that she was administering escitalopram because she noticed it was in the multi-dose pack.
-She thought the MH Provider had re-ordered the medication.

Interview with the Administrator on 08/21/23 at 4:41pm revealed:
-She expected the SIC/Owner to take new orders to the pharmacy.
-The SIC/Owner could have asked the MH Provider to electronically send the prescription to the pharmacy.
-The SIC/Owner should have noticed the medication was still in the multi-dose pack and notified the pharmacy since she knew the medication had been discontinued.
-Resident #1 could have become "sick" if she continued to take a medication the MH provider had discontinued.

Refer to the interview with the SIC/Owner on 08/18/23 at 3:44pm.

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

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C 330	Continued From page 119 unsuccessful. 2. Review of Resident #3's current FL-2 dated 06/07/23 revealed: -Diagnoses included bipolar, schizophrenia, and post-traumatic stress disorder (PTSD). -There was an order for prazosin 2mg (used for elevated blood pressure) 2 tablets every night. Review of Resident #3's July 2023 medication administration record (MAR) revealed: -There was an entry for prazosin 2mg two tablets at bedtime with a scheduled administration time of 8:00pm. -There was documentation prazosin was administered at bedtime from 07/01/23 to 07/30/23. -There was no documentation prazosin was administered on 07/31/23. Review of Resident #3's August 2023 MAR from 08/01/23-08/17/23 revealed: -There was an entry for prazosin 2mg two tablets at bedtime with a scheduled administration time of 8:00pm. -There was documentation prazosin 2mg was administered at bedtime from 08/01/23 to 08/17/23. Observation of Resident #3's medications on hand on 08/18/23 at 10:24am revealed there was no prazosin 2mg available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed: -The pharmacy had an order for prazosin 2mg 2 tablets at bedtime. -The pharmacy dispensed prazosin on 06/19/23 for 60 tablets, a 30-day supply.	C 330		

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C 330	Continued From page 120 -There were no refills on the original order so the pharmacist sent a request to the ordering physician on 06/19/23 for a prescription so the pharmacy could dispense the medication in July 2023. -The pharmacy had sent three requests to the ordering physician and had contacted the facility to assist in getting a prescription so the medication could be refilled in July 2023. -The pharmacy did not package prazosin 2mg in the multi-dose packs that were dispensed on 07/17/23 because the request for a new prescription had not been received. -The pharmacy did not have any information Resident #3 had a local Primary Care Provider (PCP). -The pharmacy had not been notified Resident #3 had a local PCP that could send a prescription for refills for prazosin. Based on observation and record reviews prazosin 2mg two tablets was available for administration from 06/19/23 to 07/18/23, but there were no prazosin 2mg tablets available for administration from 07/19/23 to 08/17/23 because the medication had not been dispensed since 06/19/23. Interview with Resident #3 on 08/18/23 at 2:23pm revealed: -He had not been receiving prazosin for several weeks. -He did not know the last time he took prazosin. -He did not know why he was not receiving prazosin. Telephone interview with a staff member at Resident #3's PCP's office on 08/21/23 at 9:31am revealed: -Resident #3 had an order for prazosin 2mg 2	C 330		

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C 330	Continued From page 121	C 330		

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 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 July 2023 appointment.

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 he had not been receiving his medication as

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C 330	Continued From page 122 ordered and needed a new prescriptions. 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. 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). 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 with a scheduled administration time of 5:00pm. -Metformin 1000mg was documented as	C 330		

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C 330	Continued From page 123	C 330		

administered from 08/01/23-08/03/23; there was a handwritten note the medication was discontinued 08/03/23.

Observation of Resident #2's medication on hand on 08/18/23 at 9:59am revealed there was no 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 supply.
-Metformin 1000mg was not dispensed in August 2023 but she was not sure why the medication had not been filled.
-The pharmacy had changed computer systems and she thought it was an error on their behalf.
-If the facility staff had called the pharmacy to ask about the medication, they would have immediately dispensed the medication.
-Resident #2's Metformin 1000mg would be sent to the facility today, 08/18/23.

Telephone interview with a nurse at Resident #2's PCP's office on 08/21/23 at 2:50pm revealed:
-Resident #2 was diabetic.
-Resident #2 had an active order for Metformin 1000mg to be administered at 5:00pm.
-If Resident #2's Metformin was not administered the resident could have an increase in his blood sugars.
-Long-term increased blood sugars could affect the resident's kidneys and if the blood sugar was too high, the resident could go into a coma.

Interview with the SIC/Owner on 08/18/23 at 4:08pm revealed:
-She thought Resident #2's Metformin had been

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C 330	Continued From page 124 discontinued because the pharmacy had not delivered the medication. -She had not seen an order to discontinue Resident #2's Metformin. -She had not called the pharmacy to ask about Resident #2's Metformin. Interview with Resident #2 on 08/18/23 at 4:28pm revealed: -He only took medication in the morning and at bedtime. -He did not know what medication he took; he took whatever the SIC/Owner gave him. -He did not know if his Metformin 1000mg had been discontinued or the last time he took the medication. Interview with the Administrator on 08/21/23 at 4:43pm revealed: -She did not know Resident #2's Metformin had not been administered since 08/03/23. -She expected the SIC/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 diabetic, and his blood sugar could have "run up." Refer to the interview with the SIC/Owner on 08/18/23 at 3:44pm. _____ Interview with the SIC/Owner on 08/18/23 at 3:44:pm revealed: -She administered medications to all the residents in the facility. -She compared the medications entered on the MAR to the list of medications on the box containing the multi-dose packs. -She made sure all the medications were available to administer.	C 330		

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C 330	Continued From page 125 -She signed the MAR after the resident took the medications. -Medication audits were performed each month the medication were delivered. -She checked the label on top of the multi-dose pack box to ensure all the medications were in the box. _____ The facility failed to ensure medications were administered as ordered for 3 sampled residents including a resident, who was diagnosed with schizophrenia, and escitalopram was discontinued related to an increase in hallucinations and paranoid thoughts, but the discontinued order was not received by the pharmacy and the medication continued to be dispensed and administered daily from 03/27/23-08/21/23 and the resident continued to have hallucinations of others stealing her items and conversing with others who were not there. (#1). This failure resulted in a substantial risk of harm and neglect to the resident, which constitutes a Type A2 Violation. _____ 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 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	C 342		

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C 342	Continued From page 126 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #3) including a medication for involuntary movements (#1); and a diuretic, a hormone replacement medication, an anxiety medication, a blood pressure medication, medication for depression, and two medications for reflux (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 11/29/22 revealed: -Diagnosis included undifferentiated schizophrenia. -There was an order for Austedo (used to treat involuntary movement) 12mg twice daily. Review of Resident #1's July 2023 medication administration record (MAR) revealed:	C 342		

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C 342	Continued From page 127 -There was an entry for Austedo 12mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documented Austedo 12mg was administered from 07/01/23 to 07/31/23 at 8:00am. -There was no documentation Austedo 12mg was administered from 07/01/23 to 07/31/23 at 8:00pm. Observation of Resident #1's medication on hand on 08/12/23 at 10:40pm revealed Austedo 12mg was packaged in the multi-dose packs twice daily and available for administration. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed: -The pharmacy had an order for Austedo 12mg twice daily for Resident #1. -The pharmacy dispensed 60 Austedo 12mg tablets on 06/15/23 and 07/17/23. Interview with Supervisor in Charge (SIC)/Owner on 08/21/23 at 10:50am revealed: -She administered Resident #1 Austedo 12mg at 8:00pm; it was in her multi-dose pack. -She did not know she did not sign the MAR for Austedo at 8:00pm. -She needed to be sure she signed the MAR when a medication was administered. Refer to the interview with the Administrator on 08/21/23 at 4:41pm. 2. Review of Resident #3's current FL-2 dated 06/07/23 revealed: -Diagnoses included bipolar disorder, schizophrenia, and post-traumatic stress disorder.	C 342		

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C 342	Continued From page 128 -There was an order for spironolactone 50mg (used to treat blood pressure) 5 tablets daily. -There was an order for Estrace 5mg (used for hormone replacement therapy) daily. -There was an order for buspirone 10mg (used to treat anxiety) three times daily. -There was an order for olanzapine 5mg (used to treat bipolar disorder) at bedtime. -There was an order for famotidine 20mg (used to treat heartburn) twice daily. -There was an order for pantoprazole 40mg (used to treat heartburn and gastric reflux) daily. -There was an order for fluoxetine 20mg (used to treat depression) at bedtime. Review of Resident #3's June 2023 medication administration record (MAR) from 06/08/23 to 06/30/23 revealed: -There was an entry for spironolactone 50mg daily with a scheduled administration time of 8:00am. -There was documentation spironolactone was administered on 06/28/23 and 06/29/23 at 8:00am. -There was no documentation spironolactone was administered from 06/08/23 to 06/27/23 and 06/30/23 at 8:00am. -There was an entry for Estrace 5mg daily with a scheduled administration time of 8:00am. -There was documentation Estrace was administered on 06/28/23 and 06/29/23 at 8:00am. -There was no documentation Estrace was administered from 06/08/23 to 06/27/23 and 06/30/23 at 8:00am. -There was an entry for buspirone 10mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation buspirone was administered on 06/27/23 at 8:00pm to 06/29/23	C 342		

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C 342	Continued From page 129 at 8:00am. -There was no documentation buspirone was administered from 06/08/23 to 06/27/23 at 2:00pm and 06/29/23 at 2:00pm to 06/30/23 at 8:00pm. -There was an entry for olanzapine 5mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation olanzapine was administered from 06/27/23 to 06/29/23 at 8:00pm. -There was no documentation olanzapine was administered from 06/08/23 to 06/26/23 and 06/30/23 at 8:00pm. -There was an entry for famotidine 20mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation famotidine was administered on 06/27/23 at 8:00pm to 06/29/23 at 8:00am. -There was no documentation famotidine was administered from 06/08/23 to 06/27/23 at 8:00am and 06/29/23 at 8:00pm to 06/30/23 at 8:00pm. -There was an entry for fluoxetine 20mg at bedtime with a scheduled administration time of 8:00pm. -There was documentation fluoxetine was administered on 06/27/23 and 06/28/23 at 8:00pm. -There was no documentation fluoxetine was administered from 06/08/23 to 06/26/23 and 06/29/23 to 06/30/23 at 8:00pm. -There was an entry for pantoprazole 40mg daily with a scheduled administration time of 8:00am. -There was documentation pantoprazole was administered on 06/28/23 and 06/29/23 at 8:00am. -There was no documentation pantoprazole was administered from 06/08/23 to 06/27/23 and	C 342		

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C 342	Continued From page 130 06/30/23 at 8:00am. Observation of Resident #3's medication on hand on 08/12/23 at 10:24pm revealed there was spironlactone, Estrace, buspirone, olanzapine, famotidine, pantoprazole, and fluoxetine were packaged in the multi-dose packs and available for administration. Interview with Resident #3 on 08/18/23 at 4:27pm revealed: -The SIC/Owner brought him his medications. -Sometimes he would take them and sometimes he would refuse, but they were always available to take. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed: -The pharmacy had an order for spironolactone 50mg 5 tablets daily. -The pharmacy dispensed 100 tablets on 08/16/23. -The pharmacy had an order for Estrace 5mg daily. -The pharmacy dispensed 30 tablets on 08/16/23. -The pharmacy had an order for buspirone 10mg three times daily. -The pharmacy dispensed 90 buspirone on 07/26/23. -The pharmacy had an order for olanzapine 5mg at bedtime. -The pharmacy dispensed 30 olanzapine on 07/26/23. -The pharmacy had an order for famotidine 20mg twice daily. -The pharmacy dispensed 40 famotidine on 08/16/23. -The pharmacy had an order for pantoprazole 40mg daily.	C 342		

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C 342	Continued From page 131 -The pharmacy dispensed 20 pantoprazole on 08/16/23. -The pharmacy had an order for fluoxetine 20mg at bedtime. -The pharmacy dispensed 30 fluoxetine on 07/26/23. Interview with the SIC/Owner on 08/21/23 at 10:50am revealed: -Resident #3 was admitted to the facility on 06/07/23. -Resident #3's medications and the June 2023 MAR were received in the facility on 06/08/23. -She placed Resident #3's medication in the medication cabinet and misplaced the June 2023 MAR. -She started documenting on the MARs when she located them. -Resident #3 received his medications starting on 06/07/23; they were in a multi-dose pack and labeled for morning or evening. Refer to the interview with the Administrator on 08/21/23 at 4:41pm. _____ Interview with the Administrator on 08/21/23 at 4:41pm revealed: -The SIC/Owner should document on the MAR immediately after the medications were administered. -She asked the SIC/Owner to place the MARs in a notebook so they would not get misplaced; she did not remember when she asked the SIC/Owner to place the MARs in a notebook.	C 342		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription	C 353		

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C 353	Continued From page 132	C 353		

medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration.

This Rule is not met as evidenced by:
Based on observation, record review, and interviews, the facility failed to ensure medications for 1 of 5 residents (#3) were stored in a locked container.

The findings are:

Observation of the medication cabinet on 08/18/23 at 8:01am revealed:
-The medication cabinet was in the living room.
-There were 5 plastic medication cups stacked on top of each other on the top of the medication cabinet.
-One of the 5 plastic medication cups contained 5 round white tablets, 1 square beige tablet, and one beige and green capsule.
-There was a resident seated in the living room.
-There was no facility staff in the living room.

Interview with the Supervisor-in-Charge (SIC)/Owner on 08/21/23 at 10:25am revealed:
-A resident refused to take his medications last night on 08/17/23.
-She thought she threw the medication out.
-She disposed of medications by placing them in a plastic bag and dropping them in the garbage.
-The garbage was taken to the landfill when needed.
-Medications should not be left out because other residents may take them.

Review of a resident's medication administration record (MAR) for 08/18/23 revealed the

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C 353	Continued From page 133 medications observed were the evening medications listed for this resident. 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 refused 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 trying to administer the medications, the medications should be disposed of in a drug buster.	C 353		
C 367	10A NCAC 13G .1008(a) Controlled Substances 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 as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure there were readily retrievable records for controlled substances by documenting the receipt, administration, and disposition for 1 of 1 sampled residents (#1) with an order for a medication used to treat anxiety. The findings are:	C 367		

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	FCL017018	A. BUILDING: _____ B. WING _____	08/21/2023

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Review of Resident #1's current FL-2 dated 11/29/22 revealed:
-Diagnosis included undifferentiated schizophrenia.
-There was an order for lorazepam 1mg (used to treat anxiety) every 8 hours as needed (PRN).

Review of Resident #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 PRN.
-There 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:
-There were 2 CSCS with a pharmacy label that read lorazepam 1mg every 8 hours as PRN on each CSCS.
-The pharmacy label read there were 42 lorazepam 1mg tablets dispensed on 03/28/23.
-There was no documentation on either CSCS lorazepam 1mg had been administered to Resident #1.

Observation of medication on hand for Resident #1 on 08/18/23 at 10:42am revealed:
-There was a bubble pack with a pharmacy label that read lorazepam 1mg every 8 hours PRN.
-The bubble pack was labeled 2 of 2 bubble packs dispensed on 03/28/23.
-There were 12 lorazepam tablets dispensed in the second bubble pack.
-There were 11 of 12 tablets remaining in the

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C 367	Continued From page 135 bubble pack. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed: -The pharmacy had an order for lorazepam 1mg every 8 hours as needed. -The pharmacy dispensed 42 lorazepam 1mg tablets on 03/28/23. -The pharmacy dispensed 30 lorazepam 1mg tablets in one bubble pack and dispensed 12 lorazepam 1mg tablets in a second bubble pack. -The pharmacy sent a CSCS with each bubble pack. -The CSCS was to be used by the medication aide to keep track of the controlled substance. Interview with the Supervisor-in-Charge (SIC)/Owner on 08/21/23 at 10:10am revealed: -She administered lorazepam to Resident #1 when she needed it. -She thought she signed the back of the MAR when she administered lorazepam to Resident #1. -She did not sign the CSCS sheets when she administered lorazepam to Resident #1. Observation of medication on hand for Resident #1 on 08/21/23 at 10:15am revealed: -There were two bubble packs dispensed on 03/28/23 for lorazepam 1mg every 8 hours as needed for Resident #1. -One bubble pack was labeled as 1 of 2. -There were 30 lorazepam tablets dispensed in the first bubble pack; 17 of 30 tablets were remaining in the bubble pack. -The second bubble pack was labeled as 2 of 2. -There were 12 lorazepam tablets dispensed in the second bubble pack; 11 of 12 tablets were remaining in the bubble pack.	C 367		

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C 367	Continued From page 136 Second interview with the SIC/Owner on 08/21/23 at 10:18am revealed: -She placed the bubble pack of lorazepam 1mg in the closet in the den. -She had administered a tablet to Resident #1, locked the medication cabinet and had the medication in her hand when she returned to her side of the house. -She placed the bubble pack of lorazepam in the closet in the den to keep it safe until she returned to the residents' living quarters. -She had forgotten the lorazepam 1mg was in the closet in the den. -She had administered lorazepam to Resident #1 but had not documented she administered the medication. Interview with the Administrator on 08/21/23 at 4:41pm revealed: -When a controlled substance was administered the SIC/Owner should document on the MAR and the CSCS. -Documentation on the CSCS kept track of the controlled substance medication. -Documentation on the MAR would let the Primary Care Provider (PCP) know when and how often the medication was administered. -She expected the SIC/Owner to document on the MAR and CSCS each time a controlled substance was administered. _____ The facility failed to ensure there was a readily retrievable record of a controlled substance by documenting on the MAR and the CSCS each time the medication was administered, leaving 13 lorazepam 1mg tablets unaccounted for. This failure was detrimental to the safety and well-being of the resident and constitutes a Type B Violation.	C 367		

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C 367	Continued From page 137 A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON AUGUST 23, 2023. A Plan of Protection was not obtained.	C 367		
C 368	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. 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: Observation of the facility on 08/21/23 at various times between 8:00am-5:00pm revealed: -The residents went in and out of the Supervisor (SIC)/Owner's private residence. -Two visitors were observed in the SIC/Owner's private residence. Observation of the closet in the SIC/Owner's private residence on 08/21/23 at 10:15 am revealed: -The SIC/Owner went to the closet in her den and retrieved a bubble pack with a pharmacy label that read lorazepam 1mg (used to treat anxiety)	C 368		

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every 8 hours PRN that belonged to Resident #1.
-The bubble pack was 1 of 2 bubble packs dispensed on 03/28/23.
-There were 30 lorazepam tablets dispensed in the first bubble pack.
-There were 17 of 30 tablets remaining in the bubble pack.

Interview with the Pharmacist at the facility's contracted pharmacy on 08/18/23 at 11:40am revealed:
-The pharmacy dispensed 42 tablets of lorazepam on 03/28/23; 30 tablets in card 1 and 12 tablets in card 2.
-Lorazepam was a controlled substance and was required under law to be kept in a locked and secure area.

Interview continued with the SIC/Owner on 08/21/23 at 10:18am revealed:
-Controlled substances should be stored under 2 locks.
-The closet door in the den where the lorazepam was located was not locked.
-The lorazepam had been in the closet about one week.
-She placed the bubble pack of lorazepam 1mg in the closet in the den.
-She had administered a tablet to Resident #1, locked the medication cabinet and had the medication in her hand when she returned to her side of the house.
-She placed the bubble pack of lorazepam in the closet in the den to keep it safe until she returned to the resident's living quarters.
-She had forgotten the lorazepam 1mg was in the closet in the den.

Interview with the Administrator on 08/21/23 at 4:41pm revealed:

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C 368	Continued From page 139 -All controlled substances should be locked under 2 locks. -Anyone could have taken the controlled substance when not locked up. -It was not safe for the residents if staff stored controlled substances in an unlocked closet. -She expected the controlled substances to be double locked.	C 368		
C 613	10A NCAC 13G .1701 (d) Infection Prevention & Control Policies & Pro 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL POLICES & PROCEDURES (d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (b)(2) of this Rule. 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), who administered medications, completed the state-mandated infection control training annually. The findings are: Review of Staff A's, Supervisor in Charge (SIC)/Owner, personnel record revealed: -She was hired in April 1985. -She worked as a medication aide. -There was a certificate for the state-mandated	C 613		

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C 613	Continued From page 140 infection control training dated November 2021. -There was no other documentation the state-mandated infection control training was completed annually. Interview with Staff A on 08/21/23 at 2:31pm revealed: -She was the SIC/Owner of the facility. -She did not know the last time she had the annual infection control training. -She thought she was scheduled for an infection control class soon, but she did not know when. -The infection control class was offered through the facility's contracted pharmacy. -The class was offered every year. -She had the class last year, but she forgot to pick up her certificate at the pharmacy. Interview with the Administrator on 08/21/23 at 4:41pm revealed: -The facility's contracted pharmacy did the annual infection control in-service. -She did not know the last time the SIC/Owner had the annual infection control in-service. -She did not know the last infection control in-service was in November 2021. -She was responsible for ensuring the SIC/Owner received her annual infection control in-service.	C 613		