Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _	A. BUILDING:		
		FCL074050	B. WING		02/09	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
L AND C F	FAMILY CARE HOME LLC	3	WAY DRIVE NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 000	Initial Comments		C 000			
		sure Section conducted an complaint investigation from February 9, 2024.				
C 105	10A NCAC 13G .031 Equipment	7(d) Building Service	C 105			
	provide an adequate kitchen, bathrooms, a temperature at all fixt be maintained at a m	7 Building Service ok shall be of such size to supply of hot water to the and laundry. The hot water ures used by residents shall inimum of 100 degrees F hall not exceed 116 degrees				
	reviews, the facility fatemperatures were median 100 degrees Fahrenh degrees F for 3 of 3 f sinks and a tub that we used by residents with	as evidenced by: ns, interviews, and record alled to ensure the hot water laintained at a minimum of neit (F) to a maximum of 116 ixtures sampled, including 2 livere readily accessible and h hot water temperatures lives are sees F to 96.5 degrees F.				
	The findings are:					
		s current license effective e facility was licensed for a nbulatory residents.				
	Review of the facility' provided on 02/08/24 current census was 6	revealed the facility's				
		ot water temperatures in a esidents shared on 02/08/24				

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDIEAN	or connection	BENTI IOATION NOMBER.	A. BUILDING: _	A. BUILDING:		LETED
		FCL074050	B. WING		02	/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		6347 FAII	RWAY DRIVE			
L AND C	FAMILY CARE HOME LLO	GRIFTON	I, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 105	Continued From page	======================================	C 105			
	at 8:50am revealed: -The hot water tempe degrees F.	erature in the sink was 95 erature in the tub was 95.6				
	bathroom that female	evealed the hot water				
	Requests for the facility's water temperature log on 02/08/24 at 11:00am and on 02/09/24 at 4:15pm were unsuccessful.					
	Interview with a resident on 02/09/24 at 8:30am revealed: -She was transferred to the facility from the owner's other facility a few weeks agoThe resident's only concern about the facility was that the water in her shower was too coldShe thought the water was around 80 to 90 degrees FahrenheitShe had skipped taking showers a couple of times because the water was too cold.					
	bathroom that male re at 4:01pm with the Activate Administrator fill with water and submount in the water. -The Administrator re thermometer from the the water from the sirustrator us thermometer to check the sink.	e bathroom sink and drained nk. sed a probe dial k the water temperature in nd surveyor checked the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02	2/09/2024
NAME OF D	ROVIDER OR SUPPLIER	STREET V	DDRESS, CITY, STATI	E ZID CODE		
NAME OF F	ROVIDER OR SUFFLIER		RWAY DRIVE	E, ZIF CODE		
L AND C	FAMILY CARE HOME LLC		N, NC 28530			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	COMPLETE DATE
C 105	Continued From page	2	C 105			
	100 degrees F and the read 96 degrees FThe Administrator and water temperature in the The Administrator's p	orobe dial thermometer read e surveyors thermometer d surveyor checked the the tub. orobe dial thermometer read e surveyors thermometer				
	bathroom that female 02/09/24 at 4:10pm re -The Administrator an water temperature in -The Administrator's p	evealed: d surveyor checked the				
	4:15pm revealed: -She checked the wat resident bathrooms eresidents assistance to -The water temperature 02/05/24 in the male to -She was unable to lo	res were 100 degrees F on resident's bathroom sink. cate a water temperature thought it was in a storage				
	02/09/24 at 12:47pm -Residents and staff r enough to practice ap -The facility needed th enough temperature t proper sanitation at th -Residents dignity and	sidents at the facility on revealed: needed water that was hot propriate infection control. ne water to be a high o kill germs and provide				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
L AND C F	FAMILY CARE HOME LLC		WAY DRIVE NC 28530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 148	(a) Each staff person shall:(8) have an examinat presence of controlled accordance with G.S.	6 Other Staff Qualifications of a family care home ion and screening for the d substances completed in	C 148		
	facility failed to ensure and screened for the substances upon hire	and record reviews, the e all staff were examined presence of controlled and results were aff person's personnel file			
	-There was no hire da -Staff B's application of -Staff B was a Medical administered medical -There was no docum	date was 11/25/23. ation Aide (MA) and ions at the facility. mentation that an ening for the presence of a			
	3:59pm revealed: -Staff B was hired on -Staff B quit the positi longer employed at th -She completed staff substances on 12/20/	on on 02/08/24 and was no ne facility. B's screen for controlled			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		FCL074050	B. WING		02/09/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		6347 FAIF	RWAY DRIVE		
L AND C F	FAMILY CARE HOME LLO	GRIFTON	, NC 28530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 148	Continued From page	<u> </u>	C 148		
C 148	substances was requ Review of the images substance test reveal -The image was date	he screen for controlled ired upon hire. s of Staff B's controlled led: d 12/20/23. e written on the top of a stion cup.	C 148		
C 212	10A NCAC 13G .0703	3 (a) Resident Register	C 212		
	10A NCAC 13G .0703	3 Resident Register			
	(a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register.				
	facility failed to ensur	and record reviews, the e the Resident Register was nours of admission to the			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
					02/09/2024	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
L AND C F	AMILY CARE HOME LLC	3	RWAY DRIVE N, NC 28530			
	OLIMANA DV. OT		,	DDOVIDEDIO DI AN OF CODDECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 212	Continued From page	÷ 5	C 212			
	11/20/23 revealed diadisorder and vitamin Interview with the Adr 8:15am revealed: -Resident #1 was trar from another facility in -She thought Resider weeks prior to the sur	ninistrator on 02/08/24 at				
	owned and operated Administrator. -Resident #1's facility	11/01/23. ity and current facility were by the same owner and healthcare records and				
	medications were included at the	luded in the transfer and current facility.				
	Review of Resident # 02/08/24, revealed th Register.					
	on 02/09/24 at 8:10ar -She completed the a Resident #1 when the the transferring facility -She gave the Admini transfer Resident #1 to 01/13/24She had not complet current facilityThe Administrator to	dmission paperwork for a resident was admitted to by in November, 2023. Strator permission to to the current facility on the day paperwork for the day the day be a would send the pardian had not received				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STAT	E ZIR CODE	
NAIVIE OF F	ROVIDER OR SUFFLIER		RWAY DRIVE	e, zir cobe	
L AND C	FAMILY CARE HOME LLC		N, NC 28530		
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
C 212	Continued From page	6	C 212		
	Interview with the Adr 11:53am revealed she	ninistrator on 02/09/24 at had not updated or Register since Resident #1			
C 214	10A NCAC 13G .0704 Information On Home	(a) Resident Contract And	C 214		
	10A NCAC 13G .0704 Information On Home	Resident Contract And			
	furnish and review with responsible person in home upon admission made to that information hadmission or amendmental be signed and dewhom it is given. This retained in the resident The information shall (1) a copy of the home specifying rates for reaccommodations, included by the foliable of service, if apor fees, and any health home has determined G.S. 131D-2(a1)(4). It is applies: (a) The contract shall administrator or superesident or his responsiven to the resident or his notified as soon as not less than 30 days the home, of any rate	formation on the family care and when changes are on. A statement indicating as been received upon nent as required by this Rule ated by each person to a statement shall be nt's record in the home. include: ne's resident contract			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			
		FCL074050	B. WING		02	/09/2024
NAME OF PROVIDER OF		6347 FA	DDRESS, CITY, STATE IRWAY DRIVE N, NC 28530	, ZIP CODE		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
accommon copy of (c) A continuous formation (d) Grasshall no (e) The charged establish Commist Assembly Note: Found book member payments	the contract for pay of each so sident's recontuities in add to be accepted a maximum meto Special Asped by the Notesion and the ly; acilities may ard from a third, charity or fat is made voluoom and board	I be provided an amended or review and signature; igned contract shall be kept rd in the home; ition to the established rates	C 214			
Based of facility facomplet the residupon and resident The find Review 11/20/23 disorder Interview 8:15am -Reside from and	in interviews a ailed to ensured and signed dent or reside mission to the s (#1). ings are: of Resident #8 revealed diagram and vitamin w with the Admirevealed: int #1 was trait therefacility in the facility in the sailed to the sailed t	as evidenced by: and record reviews, the e admission contracts were d by the Administrator and nt's responsible person e facility for 1 of 3 sampled and the s				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/0	9/2024
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
L AND C F	AMILY CARE HOME LLC	GRIFTON,	NAY DRIVE NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 214	transfer date wasResident #1 was initi transferring facility on -The transferring facility on owned and operated AdministratorResident #1's facility medications were included at the Review of Resident #02/08/24, revealed: -There was no Resident #02/08/24, revealed: -There was no Resident #1 transfer when Resident #1 transferility in January 202 Telephone interview won 02/09/24 at 8:10ar -She completed the a Resident #1 when the transferring facility -She gave the Adminitransfer Resident #1 to 11/13/24She had not complete current facilityThe Administrator tol paperwork, but the guanything from the facility in January 202 Interview with the Adminitrative with the Admin	ally admitted to the 11/01/23. ity and current facility were by the same owner and healthcare records and uded in the transfer and current facility. 1's facility record on ent Register. ot had not been completed insferred to the current entered. It is guardian in revealed: dmission contract for eresident was admitted to y in November 2023. strator permission to to the current facility on ed any paperwork for the dher she would send the lardian had not received lity. In inistrator on 02/09/24 at the had not updated or ent Contract since Resident	C 214			
C 246	10A NCAC 13G .0902	2(b) Health Care	C 246			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		FCL074050	B. WING		02/09/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
LANDCE	AMILY CARE HOME LLO	6347 FAIR	WAY DRIVE		
LANDOI	AMILI GARL HOME LEC	GRIFTON,	NC 28530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
C 246	Continued From page	9	C 246		
	to meet the routine ar of residents.	assure referral and follow-up nd acute health care needs			
	This Rule is not met TYPE A2 VIOLATION				
	Based on interviews, and record reviews, the facility failed to ensure referral and follow up with healthcare providers to meet the routine and acute health care needs of 2 of 3 sampled residents (#1, #3) including a referral to a neurosurgery specialist following a hospitalization for the evaluation and treatment of seizures and three missed follow-up appointments with her primary care provider (PCP) (#1) and failed to ensure a resident attended a follow up appointment with his PCP for an infection that the PCP prescribed the resident an antibiotic for a lump on his jaw (#3).				
	08/16/17 revealed: -The facility would proaccordance with the r	s health care policy dated ovide care and services in esident's care plan. sure that any referrals and			
	follow up appointmen	ts needed to meet the severe health care needs			
	11/20/23 revealed: -Diagnoses included D deficiency.	t #1's current FL-2 dated bipolar disorder and vitamin for lorazepam (a medication 1mg at night.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
L AND C F	AMILY CARE HOME LLC		RWAY DRIVE			
			, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
C 246	Continued From page	e 10	C 246			
	Review of Resident # revealed the resident with eating, bathing, of Review of Resident # (PCP) physician visit revealed: -Resident #1 had a hit-Resident #1 had a didisorder and her mentimpaired. Interview with the Adr 8:15am revealed: -Resident #1 was transfrom another facility in	1's care plan dated 11/20/23 required limited assistance dressing, and grooming. 1's primary care provider's note dated 11/14/23 story of seizures. agnosis of neurocognitive nory and processing were ministrator on 02/08/24 at asferred to the current facility and January 2024.				
	owned and operated Administrator. -Resident #1's facility medications were included at the were continued at the -At the time of the sur	ity and current facility were by the same owner and healthcare records and luded in the transfer and current facility. Evey on 02/08/24, Resident following a seizure 02/07/24.				
	11/27/23 revealed: -Resident #1 was adr	•				
	office on 02/08/24 at no record of a referra Resident #1.	neurosurgery specialist's 12:51pm revealed there was I or appointment for				
	reiepnone interview v	vith Resident #1's guardian	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _	A. BUILDING:		E I E D
		FCL074050	B. WING		02/0	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
LANDCE	FAMILY CARE HOME LLC	6347 FAIR	WAY DRIVE			
LANDCI	AMILY CARE HOME LLC	GRIFTON,	NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 246	11/26/23, related to songleted. -Resident #1 did not I manage her seizures -She was not aware of Summary instructions and she was not aware follow-up with the new -The facility should har follow-up appointment assisted the facility in was seen by the spector of the facility was respector of the facility was respector of the facility sent her avoid of the facility should have	m revealed: dent #1 was hospitalized on eizures. have a current neurologist to of the hospital After Visit is for medication changes are Resident #1 was to urosurgery specialist. ave notified her of necessary ats so that she could have making sure the resident cialists. with Resident #1's PCP on revealed: onsible for ensuring provider eted. er of Resident #1's 27/23. a copy of the hospital After 11/27/23. Resident #1's referral to the sist had not been made ave ensured Resident #1's urgery specialist was Resident #1 followed up of specialist for management the resident had a history of ations related to seizure eviously contributed to a mental health symptoms istory of severe agitation,	C 246			
		at #1's PCP of Resident #1's				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			D WILLS	_		
		FCL074050	B. WING		02	/09/2024
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
L AND C FAMILY CARE HOME LLC			WAY DRIVE , NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 246	Visit Summary dated -She reviewed the hodated 11/27/23, but sinstructions for Residneurosurgery specialishe thought the facil PCP's, mental health completed any necessor -Resident #1 had not with a neurosurgery scheduled an appoint seen by neurosurgery Review of Resident #11/26/23 revealed: -The resident was set 11/26/23, after she haperiod. -The resident did not -The resident was not Review of Resident #02/07/24 revealed: -The resident was transfer Emergency Medical Strelated to a witnessed that occurred at the facility admission to the hospination. The resident present Department in a posticiousness after a forehead swelling and	ospital on 11/27/23. copy of the hospital After 11/27/23. spital After Visit Summary he did not recall seeing the ent #1 to follow-up with a st in 1-2 weeks. ity's referral process was providers or other providers sary referrals. been to an appointment specialist and she had not ment for Resident #1 to be a specialist. 1's hospital records dated and 2 seizures over a 24-hour remember the episodes. It oriented to time. 1's hospital records dated ansported to the hospital by Services (EMS) on 02/07/24, a seizure lasting 2 minutes acility. Forted to have had 3 seizure by on 02/07/24 prior to obtal. Find the distribution of the energency call state (altered state of an epileptic seizure) with disconfusion. The mitted to the hospital for	C 246			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			-		
		FCL074050	B. WING		02/09/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	I E, ZIP CODE	
LANDCE	AMILY CARE HOME LLO	6347 FAII	RWAY DRIVE		
LANDCI	AWILL CARE HOWE LLC	GRIFTON	I, NC 28530		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
C 246	Continued From page	e 13	C 246		
	02/09/24 at 12:47am	royoolod:			
	-The facility was resp				
	• • •	nts were scheduled and			
	attended.				
	-Her most recent visit	with Resident #1 was on			
	11/14/23, when the re	esident was living in another			
	facility.				
	-She was not notified	that Resident #1 had			
		facility in January 2024 until			
	the Administrator calle				
	-Resident #1 was scheduled for a follow-up tele				
		rith the PCP on 01/08/24.			
	• •				
	-The Administrator ca				
		it with the PCP on 01/08/24.			
	-The Administrator ca				
	rescheduled follow-up	p appointments with the PCP			
	on 01/09/24 and 01/1	0/24.			
	-Because of Resident	t #1's recent hospitalization			
	and history of seizure	es it was important that			
	•	follow-up appointments.			
	Interview with the Adr	ministrator on 02/08/24 at			
		did not recall canceling or			
		nt #1's appointments with her			
	PCP.	it #15 appointments with her			
	FCF.				
		nt #3's current FL-2 dated			
	03/03/23 revealed:				
	-Diagnosis included s				
	-The resident was am	nbulatory, and the orientation			
	status was not docum	nented.			
	-The resident's level of	of care was other.			
	Review of Resident #	3's care plan dated 02/27/23			
	revealed:				
		e assistance with eating,			
	bathing, and groomin				
	-ne required limited a	assistance with toileting and	1		

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dressing.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		FCL074050	B. WING		02/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
L AND C F	FAMILY CARE HOME LLO	3	WAY DRIVE		
		·	NC 28530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 246	Continued From page	e 14	C 246		
		3's Resident Register was admitted to the facility			
	care provider (PCP) of revealed: -Resident #3 was see for a swollen area on -The resident was preshe scheduled a follo for 01/08/24She received a text in Administrator on 01/0 unable to keep his appean busy, and she will be resident's appointment -The PCP scheduled Resident #3 on 01/09 -The Administrator ca appointment for Residents appointment for Residents appointment for Residents appointment for Residents -Residents -R	18/24 that Resident #3 was appointment because she had was sorry she missed the nt. a follow up appointment for 1/24 via telehealth. unceled the telehealth dent #3 on 01/09/24 by text			
	schedule a follow up #3. -The Administrator inf that she would call he an appointment for R -The Administrator ha follow up appointmen 02/08/24. -The Administrator se 02/08/24 and asked if Resident #3 on 02/08 Interview with the Adr 4:30pm revealed:	ad not contacted her for a at with Resident #3 until ent her a text message on f she would like to see \$/24 at 3:30pm.			
	_	the Resident #3's PCP of ns that she had for the			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SUR COMPLETE	
		FCL074050	B. WING		02/09/	2024
	ROVIDER OR SUPPLIER	6347 FAIR	DRESS, CITY, STA WAY DRIVE NC 28530	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
C 246	PCP for Resident #3She could not remen missed his telehealth to follow up on the lur-Resident #3's lump of took the antibiotic his. Attempted interview wat 8:23am was unsuch the facility failed to endospitalized 11/26 through seizures, was referred specialist and failed to seen by the PCP after three follow-up appoin admitted to the hospit evaluation and treatm seizures. This failure of serious physical had 2 Violation. The facility provided a accordance with G.S. this violation.	d any appointments with the onber why Resident #3 appointment with the PCP mp on his jaw. On his jaw improved after he PCP prescribed. with Resident #3 on 02/09/24 cessful. Insure Resident #1, who was ough 11/27 for breakthrough d to a neurosurgery of ensure the resident was are the Administrator canceled intments. The resident was tall again on 02/07/24 for the ment of breakthrough resulted in substantial risk arm and constitutes a Type	C 246			
C 315	10A NCAC 13G .1002 (a) A family care hom	ne shall ensure contact with an or prescribing practitioner fication of orders for	C 315			

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Tag REGULATORY OR LSC IDENTIFYING INFORMATION) Tag CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C 315 Continued From page 16 (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain clarification for 1 of 3 (#1) sampled residents related to medication orders following discharge from a hospital. The findings are: Review of Resident #1's current FL-2 dated 11/20/23 revealed: -Diagnoses included bipolar disorder and vitamin D deficiencyThere was an order for lorazepam (an anti-anxiety medication) 1 mg at night.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
CAND C FAMILY CARE HOME LLC GRIFTON, NC 28530 CALL DEPTICE SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (AS) FREERIX TAG RESULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (AS) CONTINUED FROM PAGE CROSS-REFERENCED TO THE APPROPRIATE CAN STATE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE CAN STATE CROSS-REFERENCED TO THE APPROPRIATE CAN			FCL074050	B. WING		02	2/09/2024
LAND C FAMILY CARE HOME LLC (X4)ID (X4)ID PREFIX FREGULATORY OR LSC IDENTIFYING INFORMATION) C 315 C Ontinued From page 16 (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission or to the facility; (2) if orders are not clear or complete; or (3) if multiple admission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain clarification for 1 of 3 (#1) sampled residents related to medication orders following discharge from a hospital. The findings are: Review of Resident #1's current FL-2 dated 11/20/23 revealed: -Diagnoses included bipolar disorder and vitamin D deficiencyThere was an order for lorazepam (an anti-anxiety medication) 1mg at night.	NAME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
CAJID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG (EACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY) C 315 Continued From page 16 C 315 C 315	LANDC	FAMILY CARE HOME LL	6347 FAI	RWAY DRIVE			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C 315 C Ontinued From page 16 (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 or readmission on the forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain clarification for 1 of 3 (#1) sampled residents related to medication orders following discharge from a hospital. The findings are: Review of Resident #1's current FL-2 dated 11/20/23 revealed: -Diagnoses included bipolar disorder and vitamin D deficiencyThere was an order for lorazepam (an anti-anxiety medication) 1 mg at night.	LANDC	PAMILI CARE HOME LL	GRIFTON	N, NC 28530			
(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to obtain clarification for 1 of 3 (#1) sampled residents related to medication orders following discharge from a hospital. The findings are: Review of Resident #1's current FL-2 dated 11/20/23 revealed: -Diagnoses included bipolar disorder and vitamin D deficiencyThere was an order for lorazepam (an anti-anxiety medication) 1 mg at night.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
Review of Resident #1's primary care provider's (PCP) physician visit note dated 11/14/23 revealed: -Resident #1 had a history of seizuresResident #1 had a diagnosis of neurocognitive disorder and her memory and processing were impaired. Interview with the Administrator on 02/08/24 at 8:15am revealed: -Resident #1 was transferred to the current facility from another facility in January 2024Resident #1 was initially admitted to the	C 315	(1) if orders for admis resident are not dated of admission or readr (2) if orders are not c (3) if multiple admission admission or readmis forms are not the san The facility shall ensuclarification is docum record. This Rule is not met Based on observation reviews, the facility fat 1 of 3 (#1) sampled remedication orders fol hospital. The findings are: Review of Resident #11/20/23 revealed: -Diagnoses included D deficiencyThere was an order anti-anxiety medication reviews of Resident #1 (PCP) physician visit revealed: -Resident #1 had a had isorder and her mer impaired. Interview with the Admistance in the Ad	ession or readmission of the d and signed within 24 hours mission to the facility; lear or complete; or ion forms are received upon ession and orders on the ne. The that this verification or ented in the resident's as evidenced by: The sidenced by: The sidence	C 315			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		501.074050	B. WING		00/00/0004	
		FCL074050			02/09/2024	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
L AND C F	FAMILY CARE HOME LLC	6347 FAIRV GRIFTON,				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 315	Continued From page	e 17	C 315			
C 315	transferring facility on The transferring facility owned and operated Administrator. Resident #1's facility medications were incomered were continued at the There was no record Resident #1 admitted At the time of the sur #1 was hospitalized for 02/07/24. Review of a hospital #1/27/23 revealed: Resident #1 was hospital #1/27/23 for the evaluation seizures. Resident #1 was to serve a seizure was to seizure	ity and current facility were by the same owner and healthcare records and luded in the transfer and current facility. showing what medications or transferred with. evey on 02/08/24, Resident following a seizure on hafter Visit Summary dated spitalized 11/26/23 through lation and treatment of stop taking lorazepam 1mg. Start taking temazepam (a ne treatment of insomnia) 1's MARs dated 01/13/24 ealed:	C 315			
	-There was no entry f	or temazepam.				
	hand on 02/08/24 at 4 -The facility had one I lorazepam 1mg every -There were 13 pills r pack. -The pharmacy label lorazepam 1mg dispet -Temazepam was not medications.	oubble pack card for right for Resident #1. emaining in the bubble showed 30 tablets of ensed 11/27/23. c on hand in Resident #1's				
	Telephone interview v	vith a pharmacist with the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
	ROVIDER OR SUPPLIER	6347 FAIR\	PRESS, CITY, STANAY DRIVE NC 28530	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPL	ETE
C 315	facility's contracted pl 8:43am revealed: -Resident #1 was adr 11/02/23Resident #1 was ord night for sleep/anxiety -On 11/27/23 at 11:31 Resident #1's orders night, the order was s mental health provide -On 11/27/23, the pha delivered 30 tablets o bubble pack to the fac -On 11/27/23 at 2:44c hospital After Visit Su included orders for Re lorazepam and start t -The pharmacy place -The pharmacy was r temazepam because Summary did not incle -According to pharma current order for Resi lorazepam or temaze -According to the curr pharmacy, Resident # tablets in the pharma -The facility should no lorazepam after 11/27 pharmacy records the hospital After Visit Su Telephone interview w health provider on 02 -She managed Resid medications and com 11/07/23 and 01/12/2 -Resident #1 had ord	narmacy on 02/09/24 at nitted to their services on ered lorazepam 1mg each on 11/02/23. am, the pharmacy received for lorazepam 1mg every igned by Resident #1's ir. armacy dispensed and if lorazepam 1mg in a cility for Resident #1. om, the facility faxed the immary dated 11/27/23, that esident #1 to stop taking aking temazepam 30mg. d a stop on the lorazepam. Interview of the hospital After Visit and all required information. Incompany receive pam. Interview of the immary dated at the interview of the immary dated at the interview of the order for intervi	C 315			

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admitted to the previous facility on 11/02/23.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '			(X3) DATE SURVEY COMPLETED	
74101214	or connection	IDENTIFICATION NO.	A. BUILDING: _	A. BUILDING:		
		FCL074050	B. WING		02/	09/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LANDC	FAMILY CARE HOME LLO	6347 FAIR	WAY DRIVE			
LANDC	PAMILI CARE HOME LLC	GRIFTON	NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 315	Continued From page	e 19	C 315			
C 313	-Resident #1 had curl 1mg each nightShe had not changel lorazepam and thoug administered lorazepat through 02/07/24She was aware of Refor seizures 11/26/23 -She was not aware of Summary instructions taking lorazepam 1mg temazepamThe facility contacted requested she send a lorazepam to Resider facility did not mentio SummaryOn 11/27/23, she set the pharmacy for Resilorazepam 1mg every -She was concerned her of the medication hospital After Visit Su #1 required medication hospital	d or discontinued the ht Resident #1 had been am each night 11/02/23 esident #1's hospitalization through 11/27/23. of the hospital After Visit of for Resident #1 to stop g and start taking d her on 11/27/23 and a signed prescription for int #1's pharmacy, but the in the hospital After Visit int the signed prescription to sident #1 to continue or night. The facility had not notified changes included in the instance of help stabilize her haviors and the resident was psychotropic medications effects and interactions. Sible interactions if Resident dications were not red included increased increased risk for falls, alth symptoms and behaviors	U 3 1 5			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			D WING		
		FCL074050	B. WING		02/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
L AND C F	AMILY CARE HOME LLC	6347 FAI	RWAY DRIVE		
		GRIFTON	N, NC 28530		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 315	Continued From page	20	C 315		
	mental health provide a new prescription for -The mental health pr an order for Resident 11/27/23. -She thought the men clarified she wanted F	ovider sent the pharmacy			
C 330	(a) A family care hom preparation and admi prescription and non-by staff are in accorda (1) orders by a license which are maintained (2) rules in this Section and procedures. This Rule is not met a TYPE A2 VIOLATION Based on observation reviews, the facility famedications in accord for 2 of 3 sampled resorders for psychotrop medication to treat and The findings are: Review of the facility's	A Medication Administration the shall assure that the inistration of medications, prescription and treatments ance with: ed prescribing practitioner in the resident's record; and in and the facility's policies as evidenced by: as, interviews and record illed to administer lance with physician orders sidents (#1 and #3) including ic medications (#1) and a xiety (#3).	C 330		
	policy dated 08/16/17				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
L AND C F	AMILY CARE HOME LLO		RWAY DRIVE			
			I, NC 28530		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	21	C 330			
	non-prescriptions, an accordance with state -The recording of the medications on the m record should be record should be record administers the result. The staff person should administration of medical following administration. The staff person should be actually taking the medical states of Residen 11/20/23 revealed:	administration of edication administration orded by the staff person medication. uld document the cication immediately on of the medication. uld observe the resident edication. t #1's current FL-2 dated bipolar disorder and vitamin for lorazepam (a cation used for the				
	(PCP) physician visit revealed: -Resident #1 had a hi -Resident #1 had a di disorder and her men impaired. Review of Resident # orders revealed: -There was an order of lorazepam 1mg at nig	story of seizures. agnosis of neurocognitive nory and processing were 1's signed medication dated 11/27/23 for ht. onically signed by Resident				
	11/27/23 revealed:	After Visit Summary dated spitalized 11/26/23 through				

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11/27/23 for the evaluation and treatment of

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE. ZIP CODE	,	
	6347 FAIR					
LANDCF	FAMILY CARE HOME LLC	GRIFTON	N, NC 28530			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 330	Continued From page	22	C 330			
	-Resident #1 was to a benzodiazepines med treatment of insomnia Interview with the Adr 8:15am revealed: -Resident #1 was trar from another facility ir -The transferring facility medications were included and operated AdministratorResident #1's facility medications were included at the -At the time of the sur #1 was hospitalized for Review of Resident # administration records through 02/08/24 reverbere was not an enough of the control of the sur #1 was hospitalized for the sur #1 was hospitalized for the sur #1 was not an enough 02/08/24 reverbere was not an enough of the sur #1 was not an enough	ninistrator on 02/08/24 at ensferred to the current facility in January 2024. Sity and current facility were by the same owner and ensemble the current facility. The second of the seco				
	Telephone interview v	vith a pharmacist with the narmacy on 02/09/24 at				

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-The pharmacy provided MARs to the facility

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A. BUILDING: COMPLETED FCL074050 B. WING 02/09/202 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	24
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	24
COAT FAIRWAY BRIVE	
L AND C FAMILY CARE HOME LLC	
GRIFTON, NC 28530	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COI	(X5) DMPLETE DATE
C 330 Continued From page 23 C 330	
once a month. On 11/27/23 at 11:31am, the pharmacy received Resident #1's orders for lorazepam 1mg every night, the order was signed by Resident #1's mental health provider. On 11/27/23, the pharmacy dispensed and delivered 30 tablets of lorazepam 1mg in a bubble pack to the previous facility for Resident #1. On 11/27/23 at 2:44pm, the previous facility faxed the hospital After Visit Summary dated 11/27/23, the included orders for Resident #1 to stop taking lorazepam and start taking temazepam 30mg. -The pharmacy placed a stop on the lorazepam on 11/27/23. -The pharmacy was not able to fill the order for temazepam because the hospital After Visit Summary did not include all required information. -Lorazepam was not entered on Resident #1's January or February 2024 MAR because the pharmacy had placed a stop on lorazepam according to the hospital After Visit Summary. -According to the hospital After Visit Summary. -According to the hospital After Visit Summary. -According to the hospital After Visit Summary remaining in the pharmacy bubble pack because the lorazepam was stopped on 11/27/23. -The facility should not have administered lorazepam after 11/27/23 because according to pharmacy resorts the order was stopped in the hospital After visit Summary. Telephone interview with Resident #1's mental health provider on 02/09/24 at 9:33am revealed: -She managed Resident #1 synchotropic medications and completed monthly visits on	

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1mg each night.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		FCL074050	B. WING		02/0	9/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
L AND C F	AMILY CARE HOME LLC		NAY DRIVE			
		GRIFTON,	NC 20530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	Continued From page	e 24	C 330			
C 330	-During her visits on recommended to commedication orders whe each nightShe had not changed lorazepam and though administered lorazepathrough 02/07/24She was aware of Reform seizures 11/26/23She was not aware of Summary instructions taking lorazepam 1mg temazepam 30mgThe Administrator correquested she send a lorazepam to Resider Administrator did not Visit SummaryOn 11/27/23, she send the pharmacy for Resider Administrator did not Visit SummaryOn 01/19/24 the Administrator did not Visit SummaryOn 01/19/24, she send a lorazepam 1mg everyOn 01/19/24, she administered Resident #1 difficulty sleepingOn 01/19/24, she administered to the mand difficulty sleepingShe was not aware to Resident #1 showed on 11/27/23, were not #1She was concerned administered Resider medications according	intinue Resident #1's ich included lorazepam 1mg d or discontinued the ht Resident #1 had been am each night 11/02/23 esident #1's hospitalization through 11/27/23. of the hospital After Visit for Resident #1 to stop g and start taking intacted her on 11/27/23 and a signed prescription for int #1's pharmacy, but the mention the hospital After int the signed prescription to sident #1 to continue or night. Ininistrator contacted her had increased agitation and increased agitation and increased agitation	C 330			
		required medications to ntal health and behaviors prescribed numerous				

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psychotropic medications that could have side

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPL						
ANDIEAN	OF CONTROLLON	IDENTIFICATION NOWIDER.	A. BUILDING: _		O O WILL	
		FCL074050	B. WING		02/0	09/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LANDO	FAMILY CARE LIGHT LL	6347 FAIF	WAY DRIVE			
LANDC	FAMILY CARE HOME LLO	GRIFTON	NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 330	effects and interaction -Side effects and pos #1's psychotropic me administered as orde lethargy, dizziness, ir increased mental hea including agitation an -Abruptly stopping a la could have increased seizure threshold (inc- Complications of sei- injuries, increased ris and confusion. Telephone interview of 02/09/24 at 12:47am -She was not aware for administered psychol to the mental health political substitutions could contain the seizure and suicide attempts medications could contain the seizure lass -The resident was repepisodes at the facility transferred to the hos -The resident present Department in a post consciousness after a forehead swelling and	sible interactions if Resident dications were not red included increased increased risk for falls, alth symptoms and behaviors difficulty sleeping. Denzodiazepine medication the risk of lowering the creased risk of seizures). It is could include serious k of falls, difficulty breathing with Resident #1's PCP on revealed: Resident #1 was not cropic medications according provider's orders. Resident #1's medications to eactly because the resident trees, agitation, aggression and changes in her intribute to an increase in each string 2 minutes at the facility ported to have had 3 seizure by on 02/07/24, prior to being spital. It is the Emergency ictal state (altered state of an epileptic seizure) with diconfusion. In mitted to the hospital for	C 330			

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<u>Division c</u>	<u>of Health Service Regu</u>	ılation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	' '		COMPLETED	
			_			
			P WING			
		FCL074050	B. WING		02/09/2024	
NAME OF PF	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
			RWAY DRIVE			
L AND C F	FAMILY CARE HOME LLO	C				
			I, NC 28530	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		_
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		-
IAG		,	IAG	DEFICIENCY)		
			+			\neg
C 330	Continued From page	∍ 26	C 330			
	I					
	Intensions with the Ado	ministrator on 02/00/24 at				
		ministrator on 02/09/24 at				
	11:53am revealed:	I to in interned an adjusting				
	-When she or the MA's administered medications they were to verify that the order on the MAR					
		cy label on the bubble pack				
	_	ered the medications and				
		dministration on MAR.				
	· · · · · · · · · · · · · · · · · · ·	kly audits of the MARs and				
	medications on hand.					
		ter Visit Summary dated				
	11/27/23 and sent it to	o the pharmacy on 11/27/23.				
	-She contacted Resid	dent #1's mental health				
	provider on 11/27/23,	, to clarify the orders for				
	lorazepam and temaz	zepam and she notified the				
	· · · · · · · · · · · · · · · · · · ·	er that the pharmacy needed				
	a new prescription for					
		rovider sent the pharmacy				
	an order for Resident					
	11/27/24.	,				
	-There was no log tha	at showed Resident #1's				
	lorazepam was dispe					
	11/27/23.	flood to the facility of				
		ny there were 13 of 30				
		1mg remaining in Resident				
	#1's medication bubb					
	-It was important for r					
	· · · · · · · · · · · · · · · · · · ·	ng to the physician's orders				
	for the health of the re					
		kly audits of Resident #1's				
	·	<u> </u>				
		not know how she missed the				
	error for Resident #1'	•				
		that if a benzodiazepine				
	·	ptly stopped it could increase				
	the risk of seizures.					
	2. Review of Resider	nt #3's current FL-2 dated				
	03/03/23 revealed:					

-Diagnosis included schizophrenia.

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
			A. BUILDING: _			
		FCL074050	B. WING		02/	09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
L AND C	FAMILY CARE HOME LL	C	RWAY DRIVE , NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF THE APPL	OULD BE	(X5) COMPLETE DATE
C 330	tablets (3mg) every extreat anxiety). Review of Resident # revealed the resident on 11/12/19. Review of Resident # medication administration administration administration and the second of the sec	for Klonopin 1mg, take 3 evening (Klonopin is used to £3's Resident Register t was admitted to the facility £3's December 2023 ation record (MAR) revealed: for Klonopin 1mg, take 3 pm every evening. atation Klonopin 1mg, 3 dministered at 8:00pm from £3's January 2024 MAR for Klonopin 1mg, take 3 pm every evening. atation Klonopin 1mg, 3 dministered at 8:00pm from £3's February 2024 MAR for Klonopin 1mg, 3 dministered at 8:00pm from £3's February 2024 MAR for Klonopin 1mg, take 3 pm every evening. atation Klonopin 1mg, 3 dministered at 8:00pm from	C 330			
	at 4:49pm revealed the medication card with 21 Klonopin 1mg table for administration.	cations on hand on 02/08/24 here was a bubble pack a fill date of 01/05/24, with lets, a 7 day supply available with a pharmacist at the				
		harmacy on 02/09/24 at				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COMPLETED		(X3) DATE SURVEY COMPLETED
ANDIEAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		OOM! LETED
		FCL074050	B. WING		02/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
L AND C F	FAMILY CARE HOME LL	C	RWAY DRIVE		
		GRIFTON	, NC 28530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
C 330	Continued From pag	e 28	C 330		
	10:19am revealed:				
		olets were dispensed for			
		9/23; a 30 day supply.			
		olets were dispensed for 5/24, a 30 day supply.			
	Resident #3 on 0 1/00	orza, a 50 day suppry.			
	Telephone interview	with Resident #3's			
		/24 at 10:00am revealed:			
		istory of hallucinations and			
	delusions.	nacidant bassalasa			
	-Klonopin helped the hallucinations and de				
	-When Resident #3 was not administered his				
	Klonopin as prescribe	ed he had increased			
	_	anxiety, insomnia, and			
	restlessness.				
	as ordered, he would	not administered his Klonopin			
		elusions, and she would need			
		chotic he was prescribed.			
	Talanhana intervious	with Resident #3's primary			
	•	on 02/09/24 at 12:47pm			
	revealed:	on 62,66,21 at 12.17 pm			
	-Resident #3 was pre	escribed Klonopin to help			
		allucinations, and delusions.			
		risk of increased delusions,			
		ry, agitation, insomnia, and a The did not receive his			
	Klonopin every eveni				
		ministrator on 02/09/24 at			
	11:48am revealed:	esident #3 Klonopin 1mg, 3			
		esident #3 Klonopin Tring, 3 evening before bedtime.			
	-Resident #3 had nev	_			
	prescribed medicatio				
		ot receive his medications as			
		y immature, played in the			
	toilet, and put objects	s in his ears and nose.			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COM		
		FCL074050	B. WING		02/09/	/2024
	ROVIDER OR SUPPLIER FAMILY CARE HOME LLC	6347 FAIF	DRESS, CITY, STAT RWAY DRIVE , NC 28530	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
C 330	in the past six months Klonopin every night a -She could not explain day supply of Klonopi The facility failed to e a history of seizures, attempts, was adminimedications according placed the resident at effects and/or medical stopping Resident #11 resident at an increas related to seizures and hospitalized for seizures and hospitalized for seizures and administered his med increase in in hallucin agitation, and insomn	had any behavioral issues and had received his at bedtime. In why Resident #3 had a 7 in on hand. Insure Resident #1, who had agitation and suicide stered her psychotropic g to physician's orders in risk of experiencing side tion interactions, abruptly is lorazepam placed the led risk for serious injury	C 330			
C 335	Type A2 Violation. The facility provided a accordance with G.S. this violation. THE CORRECTION I VIOLATION SHALL N 2024. 10A NCAC 13G .1004 Administration 10A NCAC 13G .1004 (f) If medications are in advance, the follow	a plan of protection in 131D-34 on 02/09/24 for DATE FOR THE TYPE A2 IOT EXCEED MARCH 10,	C 335			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 02/00/2021	
L AND C	FAMILY CARE HOME LLC	6347 FAIRV GRIFTON, I				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 335	contamination and sp (1) Medications are package such as unit labeled with the name strength in the sealed package of medicatio and kept enclosed in container that is label until the medications resident. If the multi- resident's name, it do in a capped or sealed (2) Medications not labeled package as s of this Paragraph are container that identifie each medication prep name; (3) A separate conta resident and each pla medications and labe Subparagraph (1) or (4) All containers are separate tray or other the planned time for a	ation and protect them from illage: dispensed in a sealed dose and multi-paks that is e of each medication and I package. The labeled ns is to remain unopened a capped or sealed ed with the resident's name, are administered to the pak is also labeled with the es not have to be enclosed I container; dispensed in a sealed and pecified in Subparagraph (1) kept enclosed in a sealed es the name and strength of each and the resident's hiner is used for each anned administration of the led according to (2) of this Paragraph; and e placed together on a redevice that is labeled with administration and stored in sonly accessible to staff as	C 335			
	reviews, the facility fathat were prepared for were stored in a seale medication from container name of the resident	as evidenced by: as, interviews, and record iiled to ensure medications or administration in advance ed container to protect the amination or spillage and was labeled to identify the and name and strength of of 3 sampled residents (#1).				

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUPPLIAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
			A. BUILDING: _			
		FCL074050	B. WING		02	/09/2024
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
L AND C FA	MILY CARE HOME LLC		RWAY DRIVE , NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 335	Continued From page	e 31	C 335			
F F F F F F F F F F F F F F F F F F F	policy on 02/09/24 reverse the policy was dated. The policy was dated. The facility did not all medications. All medications were packaging until they revealed the policy was an order facility on the transferring facil	d 03/2017. flow staff to pre-pour to remain in their original feached the client. fl's current FL-2 dated fignoses included bipolar be deficiency. ministrator on 02/08/24 at finsferred to the current facility fin January, 2024. fially admitted to the finsty and current facility were fly the same owner and fine healthcare records and fluded in the transfer and fine current facility. for on 02/08/24, Resident following a seizure on for risperidone 2mg, 1.5 for risperidone 50mg at night, for lamotrigine 150mg twice				

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED			
ANDILAN	SI GORREOTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		CON	LLTLD
		FCL074050	B. WING		02	/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LANDO	TAMILY CARE HOME III	6347 FAIF	RWAY DRIVE			
LANDCI	FAMILY CARE HOME LLO	GRIFTON	, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
C 335	dated, 11/27/23. Observations of Resinand on 02/08/24 at 4-There was a bubble remaining, was labele label that read risperi &1/2 tablets 1.5 table 01/13/24. -There was a bubble remaining, that was lated that read trazodone 501/28/24. -There was a bubble remaining, that was lated that read lamotrigine Dispensed on 01/15/2. -There was a bubble remaining, that was lated that read quetiapine 501/19/24. -There was a bubble 501/19/24.	for lorazepam 1mg at night dent #1's medications on 4:06pm revealed: pack, with 10 of 30 doses ed with a with a pharmacy done tablet 2mg, take 1 ts twice daily, dispensed on pack, with 27 of 30 doses abeled with a pharmacy label 60mg at night dispensed on pack, with 17 of 30 doses abeled with a pharmacy label 150mg twice daily.	C 335			
	Observations of the facart on 02/09/24 at 12 -There was a medica initial's written on the -The cup contained 2 six sided yellow table -The cup was stored medication cartThe top drawer of the	tion cup with Resident #1's side. round white tablets and 1 t in the top drawer of the e medication cart contained markers, scissors, a stapler,				

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	FOF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02	2/09/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	, ,	
NAME OF T	NOVIDEN ON OUT FEET		RWAY DRIVE	ZII OODE		
L AND C F	FAMILY CARE HOME LLC		N, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 335	Continued From page	33	C 335			
	contaminationThe cup was not lab	ered or sealed to prevent eled with the resident's rength of each medication in				
	12:15pm revealed: -The Administrator br that belonged to Resi tableThere were initials o medication cup writte belonged to Resident -There were two cups -Both cups contained an F84 printed in blace	n in black, the initials				
	D95 imprinted on one round yellow tablet w of the tablet, and one tablet with RI4 imprin -The third medication six-sided beige tablet side of the tablet, one imprinted on one side	with D95 imprinted on one round yellow tablet with RI4 of the tablet, and one half ablet with RI4 imprinted on				
	12:29pm revealed: -She did not know wh stored in the medicat sealed or labeledShe thought the medicat prepared the medicat did not administer the	to the hospital on 02/07/24.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
L AND C F	FAMILY CARE HOME LLC	3	WAY DRIVE NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 335	Continued From page	e 34	C 335			
	medications was no longer employed at the facility as of 02/08/24.					
C 342	C 342 10A NCAC 13G .1004(j) Medication Administration		C 342			
	(j) The resident's merecord (MAR) shall be following: (1) resident's name; (2) name of the medic (3) strength and dosa medication administe (4) instructions for ador treatment; (5) reason or justificate medications or treatmed (7) documentation of medications or treatmomission, including reference (8) name or initials of the medication or treasignature equivalent to	red; ministering the medication tion for the administration of nents as needed (PRN) and ulting effect on the resident; dministration; any omission of nents and the reason for the efusals; and the person administering atment. If initials are used, a to those initials is to be intained with the medication				
	interviews, the facility	ns, record reviews, and failed to ensure the cation administration records				
	The findings are:					
	Review of the facility's policy dated 08/16/17	s medication administration revealed:				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1, ,	(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02	/09/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
L AND C F	FAMILY CARE HOME LLC	3	WAY DRIVE NC 28530				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
C 342	administration of medianon-prescriptions, an accordance with state -The recording of the medications on the medications on the medications on the medications on the medications of medications prior to the different resident's medication, and dosage or quantical dosage or quantical different resident's name, name and dosage or quantical different resident for the present of the person of the omission of medication, if initial and equivalent to those in and maintained with the resident for the person of the person	insure the preparation and lications, prescriptions and direatments by staff are in a law and licensing. I administration of ledication administration or ledication administration or ledication. I addication administration ledication. I document the lication immediately ledication immediately ledication immediately ledication, pre-charting is ledication, pre-charting is leadication, pre-charting is leadication, strength ledication administration record ledication and licing as needed and litting effect on the resident, inistration, documentation of lications as needed and litting effect on the reason for grefusals, and the name or leadministering the lications are leded and litting the lication and the reason for grefusals, and the name or leadministering the lications are lications as a signature litials should be documented licals should be documented licals should be documented licals should be documented licals should ledication ledicat	C 342	DEFICIENCY)			
		3's Resident Register was admitted to the facility					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02	2/09/2024
NAME OF D	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	: ZIR CODE	, ,	
NAME OF T	NOVIDEN ON 3011 EIEN		IRWAY DRIVE	., ZII GODE		
L AND C	FAMILY CARE HOME LLO		N, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 342	on 11/12/19. Review of Resident # electronic medication (eMAR) revealed: -There was an entry f tablets (3mg) at 8:00g-There was documen tablets (3mg) were at 12/01/23 to 12/31/23. Review of Resident # revealed: -There was an entry f tablets (3mg) at 8:00g-There was documen tablets (3mg) were at 01/01/24 to 01/31/24. Review of Resident # revealed: -There was an entry f tablets (3mg) were at 01/01/24 to 01/31/24. Review of Resident # revealed: -There was an entry f tablets (3mg) at 8:00g-There was documen tablets (3mg) at 8:00g-There was documen tablets (3mg) were at 02/01/24 to 02/06/24. Observation of medicat 4:49pm revealed the tablets, a 7 day supple administration. Review of Resident # substance record (CS-There was a CSR series Resident #3's Klonop band.	3's December 2023 administration record for Klonopin 1mg, take 3 om every evening. tation Klonopin 1mg, 3 dministered at 8:00pm from 3's January 2024 eMAR for Klonopin 1mg, take 3 om every evening. tation Klonopin 1mg, 3 dministered at 8:00pm from 3's February 2024 eMAR for Klonopin 1mg, 3 dministered at 8:00pm from ations on hand on 02/08/24 here were 21 Klonopin 1mg y available for 3's January 2024 controlled 6R) revealed:	C 342	DEFICIENCY)		
		with Klonopin 1mg, take 3 vening, a dispensing date of				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		FCL074050	B. WING		02	2/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
LANDCE	EAMILY CARE HOME LL	6347 FAI	RWAY DRIVE			
LANDCI	FAMILY CARE HOME LL	GRIFTON	N, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 342	01/05/24, and a quaral The CSR had a space administered the medication was a given and the amountained The CSR was blank. Attempted interview of at 02/09/24 at 8:23 and Telephone interview of acility's contracted particles and the seriod of	ntity of 90 tablets. ce for staff to sign if they dication, the date and time administered, the amount at of the Klonopin remaining. with Resident #3 on 02/09/24 on was unsuccessful. with a pharmacist at the harmacy on 02/09/24 at olets were dispensed for 6/23; a 30 day supply. blets were dispensed for 6/24, a 30 day supply. with Resident #3's //24 at 10:00am revealed: resident have less elusions. vas not administered his ed he had increased anxiety, insomnia, and	C 342	DEFICIEN	CY)	
	control his anxiety, ha -Resident #3 was at i hallucinations, anxiet	escribed Klonopin to help allucinations, and delusions. risk of increased delusions, y, agitation, insomnia, and a he did not receive his ng at 8:00pm.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		FCL074050	B. WING		02	2/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STATE	, ZIP CODE	·	
LANDCI	FAMILY CARE HOME LL	6347 FA	IRWAY DRIVE			
LANDCI	FAMILY CARE HOME LL	GRIFTO	N, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 342	Continued From pag	e 38	C 342			
C 365	11:48am revealed: -She completed med which included comp physician orders, the handShe or the medicatic Resident #3 Klonopin evening before bedtitionary and documented she klonopin every evening every evening before bedtitionary way she was ab resident had a 7 day Attempted interview at 02/09/24 at 8:23am 10A NCAC 13G .100	on aide (MA) administered in 1mg, 3 tablets (3mg) every ime. adde mistakes on the MARs administered the resident ing when the resident did not every evening, that was the le to understand how the supply of Klonopin available. with Resident #3 on 02/09/24 in was unsuccessful.	C 365			
	resident's name, the medication, the amounthe method of destru facility and the signatine administrator's dethe pharmacist, dispe	nacy shall include the name and strength of the unt destroyed or returned, ction if destroyed in the ture of the administrator or esignee and the signature of ensing practitioner or their cords shall be maintained by				
	reviews, the facility fa	as evidenced by: ns, interviews, and record ailed to return medications sidents to the facility's				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		
		FCL074050	D. WING		02/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
L AND C F	FAMILY CARE HOME LL	C	WAY DRIVE		
		GRIFTON	, NC 28530	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
C 365	Continued From page	e 39	C 365		
	contracted pharmacy discharged (#4).	after a resident was			
	The findings are:				
	policy dated 08/16/17 -When residents are should be released to resident has a physic medicationPrescribed medication other staff or resident -Medications, excludi should be destroyed the pharmacy within discontinuation of the death of a residentAll medication destroyed by the Adna licensed pharmacis designee of a licensed	discharged, medications o go with the resident, if the sian order to continue the ons are the property of the not be given to, or taken by,			
	person can use, adm medication.	uld be conducted so that no inister, sell, or give away the ons destroyed or returned to			
	the pharmacy will inc name and strength of destroyed or returned	lude the resident's name, the f the medication, the amount d, the method of destruction cility and the signature of the			
	administrator or the a the signature of the li dispensing practition licensed pharmacist of -These records shoul facility for a minimum	administrator's designee and censed pharmacist, er or designee of the or dispensing practitioner. Id be maintained by the of one year.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		D WING			
	FCL074050	B. WING		02/09/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
L AND C FAMILY CARE HOME LLC	6347 FAIR\ GRIFTON,	WAY DRIVE			
OVA JO STATE	EMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	NI OVE	
PREFIX (EACH DEFICIENCY M	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLET	
C 365 Continued From page 4	10	C 365			
-Scratch out or remove on the prescription label to protect the identity of -Place the medications non-descript containers mix with water or coffee medications. -Mix with an undesirable coffee grounds so the mappealing and unrecognintentionally go through -Tightly seal the contain Review of Resident #4's 11/20/23 revealed: -Diagnoses of pulmonar major depressive disord pulmonary disease (CO disability. -There was an order for one tablet every day at used to treat heartburn) -There was an order for one tablet every day at medication used to contablet every day at medication used to contablet every day at used to treat depression. -There was an order for one tablet every day at used to treat depression. -There was an order for take one tablet at 8:00am as used to treat symptoms. -There was an order for take one tablet daily at 8 one tablet d	all identifying information of the original container of the resident. In an impermeable, such as a coffee can, and of to dissolve the e substance such as used medications will be less mizable to people who may of the facility's trash. There and throw it away. In current FL-2 dated The people who may of the facility's trash. The people who may of the facility trash. The people who may of the facility trash. The people who may of the people who may of the facility trash. The people who may of the people who may of the facility trash. The people who may of the facili	C 365			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
			7 BOILBING.			
		FCL074050	B. WING		02/0	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
L AND C F	FAMILY CARE HOME LLO	3	WAY DRIVE			
	Г	GRIFTON,	NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 365	Continued From page	e 41	C 365			
C 365	11:30am revealed: -Resident #4 was disconsider that was disconsidered that was after the resident was a stee was after the resident was after the resid	charged on 12/09/23 when a to pick him up from the forgot to take the resident's when she left the facility with amily member by telephone autes after the resident left er and asked the family he facility to pick up the s. did not return to pick up the s. did not return to pick up ations. #4's medications away a few at's family did not return to dications. lent's medications in a larg, and placed the plastic sh can that goes to the street ly. Pystem in place to document equantity of medications she not think to contact the harmacy to ask about ions to the pharmacy. Incations on hand on 02/08/24 here were no medications for a for administration. Cility's front porch on evealed there was a locked harmacy to deliver	C 365			
	2:56pm revealed:	contract with the facility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE S COMPL		
		FCL074050	B. WING		02/0	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
L AND C	FAMILY CARE HOME LL	C	IRWAY DRIVE N, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 365	which included a pro appropriately return in -The facility should he to inform that Reside needed to be returned. -The pharmacy would return process, and that would drop off me resident's medication facility's front porch. -The facility should in #4's medications in a	cess for the facility to medications to the pharmacy, ave contacted the pharmacy and #4 had medications that ad. d create a label to set up the he driver for the pharmacy aredications would retrieve the as from a locked box on the ot have disposed of Resident a trash roll out cart that went anyone could find and take	C 365			
C 367	10A NCAC 13G .100 (a) A family care hor retrievable record of documenting the rec disposition of control records shall be main record and in such a accurate reconciliation. This Rule is not met Based on observation reviews, the facility for record of controlled state the receipt, administration controlled substance residents (#1 and #3 controlled substance). The findings are:	as evidenced by: ns, interviews and record ailed to maintain an accurate substances that documented ration, and disposition of s for 2 of 2 sampled) who had orders for s. 's controlled substance policy	C 367			

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	<u>E</u> TED
		FOL 074050	B. WING		00/0	0/0004
		FCL074050	B. WC		02/0	9/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	ATE, ZIP CODE		
		6347 FAIR	WAY DRIVE			
L AND C F	AMILY CARE HOME LLO	3	NC 28530			
	CLIMMA DV CT			DROVIDEDIS DI ANI OF CORRECTIO	NI.	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI		DATE
				DEFICIENCY)		
			 			
C 367	Continued From page	e 43	C 367			1
	-The facility would do	cument receipt of controlled				
	_	ration, and disposition of				1
	controlled substances	•				1
	-Controlled substances					1
	•					1
		esident's record and in such				I
		in be accurate reconciliation.				I
	_	es should be counted at the				I
		e Administrator and one				I
	other designated staff					I
	amounts and account	tability.				I
						1
	 Review of Resider 	nt #1's current FL-2 dated				I
	11/20/23 revealed:					1
	-Diagnoses included	bipolar disorder and vitamin				I
	D deficiency.	•				I
	-There was an order t	for lorazepam (an				I
	anti-anxiety medication					1
	,	,				1
	Interview with the Adr	ministrator on 02/08/24 at				I
	8:15am revealed:	11111011011011011011011111111111111111				I
		nsferred to the current facility				I
	from another facility in	•				I
						I
	-Resident #1 was initi	,				I
	transferring facility on					I
	•	ity and current facility were				I
	-	by the same owner and				I
	Administrator.					I
	•	healthcare records and				I
		luded in the transfer and				I
	were continued at the	current facility.				
						I
		1's signed medication				
	orders upon admission	on to the facility, dated				
	11/01/23, revealed the	ere was an order for				
	lorazepam 1mg every	night for anxiety/insomnia.				
		-				
	Review of Resident #	1's medication orders				
	revealed:					
		for lorazenam 1mg at night				ı

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dated 11/27/23.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU	
ANDIEAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _		OOWII LL	
		FCL074050	B. WING		02/09	/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
L AND C F	AMILY CARE HOME LLO	6347 FAIR	WAY DRIVE			
	7	GRIFTON,	NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 367	Continued From page 44		C 367			
	-The order was electronically signed by Resident #1's mental health provider.					
	11/27/23 revealed: -Resident #1 was hos	After Visit Summary dated spitalized 11/26/23 through				
	seizures.	uation and treatment of stop taking lorazepam 1mg.				
	-Resident #1 was to start taking temazepam 30mg at night for sleep.					
	through 02/08/24 reve					
	-There was not an en -There was not an en	•				
	hand on 02/08/24 at 4 -The facility had one	bubble pack card for				
	-The pharmacy label lorazepam 1mg dispe					
		ts of lorazepam remaining in				
		t on hand in Resident #1's				
	-There was no record receipt, administration controlled substances					
	facility's contracted pl 8:43am revealed:	with a pharmacist with the harmacy on 02/09/24 at				
	11/02/23.	mitted to their services on				
	night for sleep/anxiety	ered lorazepam 1mg each y on 11/02/23.				
		anti-anxiety medication and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			/ DOILDING			
		FCL074050	B. WING		02/09/20	024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LANDCI	FAMILY CARE HOME LLC	6347 FAIF	RWAY DRIVE			
- LAND O	AMILI GARLITOMIL LEC	GRIFTON	, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
C 367	Continued From page	e 45	C 367			
	-The pharmacy was not resident #1's lorazepthe order did not inclu-On 11/27/23 at 11:31 Resident #1's orders night, the order was somental health provide -On 11/27/23, the phadelivered 30 tablets of bubble pack to the factor of the pharmacy of the pharmacy place and the pharmacy place of the pharmacy was not the pharmacy was not the pharmacy was not the pharmacy was not the pharmacy of the pharmacy of the pharmacy of the pharmacy of the pharmacy was not the pharmacy of the	not able to fill or dispense parm on 11/02/23 because ude all required information. Itam, the pharmacy received for lorazepam 1mg every signed by Resident #1's err. armacy dispensed and of lorazepam 1mg in a cility for Resident #1. om, the facility faxed the mmary dated 11/27/23, that resident #1 to stop taking start taking temazepam. In a stop on the lorazepam. In a table to fill or dispense the the order on the hospital did not include all required. It order for Resident #1 to the pharmacy bubble pack that pharmacy bubble pharmacy bu				

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as of 02/08/24.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	CONSTRUCTION	(X3) DATE SUR' COMPLETE		
		FCL074050	B. WING		02/09/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STAT	E, ZIP CODE		
L AND C	FAMILY CARE HOME LLC		IRWAY DRIVE N, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
C 367	Continued From page	÷ 46	C 367			
	03/03/23 revealed: -Diagnosis included s -There was an order tablets (3mg) every e treat anxiety). Review of Resident # medication administration -There was an entry fablets (3mg) at 8:00pThere was document	for Klonopin 1mg, take 3 vening (Klonopin is used to 3's December 2023 ation record (MAR) revealed: or Klonopin 1mg, take 3				
	revealed: -There was an entry f tablets (3mg) at 8:00p -There was documen	3's January 2024 MAR or Klonopin 1mg, take 3				
	revealed: -There was an entry f tablets (3mg) at 8:00p -There was documen	tation Klonopin 1mg, 3 Iministered at 8:00pm from				
	February 2024 contro	#3's December 2023 and lled substance record 11:10am and 5:00pm from unsuccessful.				
	Review of Resident # revealed: -There was a CSR se	3's January 2024 CSR cured to the back of				

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1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:	
		FCL074050	B. WING		02/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
LANDCI	FAMILY CARE HOME LLO	6347 FAII	RWAY DRIVE		
	, , , , , , , , , , , , , , , , , , , ,	GRIFTON	I, NC 28530		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 367	Continued From page	e 47	C 367		
	Resident #3's Klonop band. -The CSR had a print contracted pharmacy tablets (3mg) every e 01/05/24, and a quan -The CSR had a space administered the medication was a given and the amount -The CSR was blank. Observation of medicat 4:49pm revealed the tablets, a 7 day supple administration. Telephone interview of facility's contracted ple 10:19am revealed: -90 Klonopin 1mg tab Resident #3 on 12/09 -90 Klonopin 1mg tab Resident #3 on 01/05 -The pharmacy sent a controlled substance when a controlled substances and de -The facility should m staff counting off with controlled substances ensure Resident #4 resident	in bubble card with a rubber led label from the facility's with Klonopin 1mg, take 3 vening, a dispensing date of tity of 90 tablets. lee for staff to sign if they dication, the date and time dministered, the amount tof the Klonopin remaining. lations on hand on 02/08/24 here were 21 Klonopin 1mg y available for with a pharmacist at the harmacy on 02/09/24 at lets were dispensed for			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY ETED
FCL074050		B. WING		02/09/2024		
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	TE, ZIP CODE		
LANDC	FAMILY CARE HOME LLO	6347 FAI	RWAY DRIVE			
LANDC	PAWIET CARE HOWE LEG	GRIFTON	N, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 367	Continued From page	e 48	C 367			
	Telephone interview of care provider (PCP) of revealed: -Resident #3 was precontrol his anxiety, had a system followed the law, ensidiversion, and to ensiadministered medicates and the enditor of the fact of th	with Resident #3's primary on 02/09/24 at 12:47pm escribed Klonopin to help allucinations, and delusions. ave CSR to ensure the in place to ensure the facility oure there was no drug ure the resident was tions as ordered. cility to count controlled d of each shift. ministrator on 02/09/24 at esident #3 Klonopin 1mg, 3 evening before bedtime. Ver been out of his ns. ot receive his medications as y immature, played in the is in his ears and nose. It had any behavioral issues is and had received his at bedtime. In why Resident #3 had a 7 in on hand. ministrator on 02/09/24 at Resident #3 but did not R. In CSR sent from the facility's is secured to the back of the it was sufficient. It that another medication aide the facility made the mistake on Resident #3's CSR.				

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-She was not sure why she or the MA had not

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02	/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
L AND C	FAMILY CARE HOME LLC		RWAY DRIVE I, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 367	Klonopin on the CSR	inistration of Resident #4's vith Resident #3 on 02/09/24	C 367			
C 370	10A NCAC 13G .1006 10A NCAC 13G .1006 (d) If the pharmacy v controlled substance, administrator's design controlled substance expiration or disconting substance or followin The destruction shall	8 (d) Controlled Substances 8 Controlled Substances will not accept the return of a the administrator or the nee shall destroy the within 90 days of the nuation of the controlled g the death of the resident. be witnessed by a licensed ng practitioner, or designee	C 370			
	practitioner. The des so that no person car away the controlled substances resident's name; the form of the controlled destroyed; the metho signature of the admi administrator's designlicensed pharmacist, designee of the licensed dispensing practitioned. This Rule is not met	truction shall be conducted in use, administer, sell or give substance. Records of sedestroyed shall include the name, strength and dosage substance; the amount dof destruction; and, the inistrator or the nee and the signature of the dispensing practitioner or sed pharmacist or er.				
	Based on interviews a facility failed to return medication to the faci	and record reviews, the a controlled substance lity's contracted pharmacy s discharged from the facility				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02	/09/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
		6347 FAII	RWAY DRIVE			
L AND C	FAMILY CARE HOME LLO	GRIFTON	I, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 370	Continued From page	e 50	C 370			
		ponsible party forgot to take her at the time of discharge				
	The findings are:					
	dated 08/17/17 reveal -The facility should do substances, administ controlled substances -Controlled substance maintained with the rean order that there cale. Controlled substance discontinued, or no low will be returned to the expiration or discontinued with the returned or followinto the facility should do name, the name, streethe controlled substance or followinto the controlled substance or followinto	cocument receipt of controlled ration, and disposition of s. e records should be esident's record and in such in be accurate reconciliation. es that are expired, enger required for a resident e pharmacy within 90 days of muation of the controlled g the death of a resident. Experiment the resident's night, and dosage form of ince; and the amount				
	Administrator's designation or discontinuous expiration or discontinuous substance or followin autoria expiration or discontinuous expiration or discontinuous expiration shoul licensed pharmacist, designee of a licensed practitioner. -The destruction should person can use, admicontrolled substanceRecords of controller should include the resistength, and dosage	within 90 days of the nuation of the controlled g the death of the residents. If the witnessed by a dispensing practitioner, or d pharmacist or dispensing the conducted so that no inister, sell or give away the				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.25 (6			
FCL074050		FCL074050	B. WING		02/0	9/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
L AND C	FAMILY CARE HOME LLC	6347 FAIRV GRIFTON, I				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETE DATE
C 370	Continued From page	e 51	C 370			
	or the Administrator's of the licensed pharm practitioner or design pharmacist or dispension of the receipt or return substance. Records of the contribute pharmacy or dest maintained by the fact years. Review of Resident # 11/20/23 revealed: -Diagnoses of pulmor major depressive discipulmonary disease (Odisability. -There was an order take one tablet daily as	ee or the licensed sing practitioner. umentation by the pharmacy				
	11:30am revealed: -Resident #4 was disconsisted family member came facilityThe family member famedications with her Resident #4She spoke with the family member famedications with the family members.	charged on 12/09/23 when a to pick him up from the forgot to take the resident's when she left the facility with				
	with his family membremember to return to the resident's medication. The family member of Resident #4's medical	did not return to pick up				

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	of Health Service Regu				ı	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		CONFLETED	
		FCL074050	B. WING		02/09/2024	
NIAME OF T	DOL/IDED OD CLUBSLUED		DDDE00 0:7/ 07:3	F. 710 000F		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
L AND C F	AMILY CARE HOME LLO		RWAY DRIVE			
		GRIFTON	N, NC 28530			
(X4) ID	-	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-1-)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		
TAG	REGULATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	MAIL SALE	
C 370	Continued From page	e 52	C 370			
	few days after the res	sident's family did not return				
	to get the resident's n					
		lent's Phenobarbital in a				
		ag, and placed the plastic				
		sh can that goes to the street				
	to be picked up week	-				
		-				
		system in place to document				
		quantity of medications she				
	disposed of; she did not think to contact the					
	•	harmacy to ask about				
	returning the medicat	ions to the pharmacy.				
	Observations of medi	ications on hand on 02/08/24				
	-	nere were no medications for				
	Resident #4 available					
	TCSIGCITE #4 available	, for administration.				
	Observation of the fa	cility's front porch on				
		evealed there was a locked				
	secured box for the p					
	medications to the fac					
	modications to the la	omty.				
	Telephone interview v	with a pharmacist from the				
	-	harmacy on 02/08/24 at				
	2:56pm revealed:					
	•	contract with the facility				
	which included a prod	,				
		nedications to the pharmacy.				
		ave contacted the pharmacy				
		nt #4 had medications that				
	needed to be returne					
		d create a label to set up the he driver for the pharmacy				
	-	edications would retrieve the				
		s from a locked box on the				
	facility's front porch.	Albana diamana di CD (1)				
	•	ot have disposed of Resident				
		trash roll out cart that went				
		anyone could find and take				
	the resident's medica	tions.	1			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		FCL074050	B. WING		02/09/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
LANDCE	AMILY CARE HOME LLO	6347 FAII	RWAY DRIVE			
LANDOI	AMIET GARE HOME EE	GRIFTON	I, NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
C 370	Continued From page	e 53	C 370			
	Telephone interview of psychiatrist on 02/09/ -She expected the fact substance medication ensure Resident #4's destroyed properlyThe Administrator play when she disposed of Phenobarbital in the tastreetIf another individual they may drove a vehicle after a placed themselves are left an individual took of from the trash roll out death due to adverse the trash roll out death due to adverse the placed themselves are provider (PCP) of the facility should have the first placed themselves are provider (PCP) of the facility should have the f	with Resident #4's 24 at 10:00am revealed: cility to have a controlled in disposal policy in place to phenobarbital was acced other individuals at risk if Resident #4's rash roll out cart to the took the resident's ay become "high," if they taking the medication, they and others at risk of death. Resident #4's Phenobarbital cart they were at risk of side effects. with Resident #4's primary on 02/09/24 at 12:47pm ave disposed of Resident er the facility's policy. acced others at risk when she ent's Phenobarbital in the ause anyone could have				
	-If someone took Resident #4's Phenobarbital that was in the trash they were at risk of oversedation, respiratory depression which could lead to death. Interview with the Administrator on 02/09/24 at 11:48am revealed: -She did not think about the facility's policy on the proper disposal of controlled substances when she disposed of Resident #4's PhenobarbitalShe thought the quickest way to get rid of his controlled substance was to place the medication in a plastic bag, tie the bag and dispose of it in					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL074050	B. WING		02/09/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
LANDCE	AMILY CARE HOME LLC	(6347 FAIR	WAY DRIVE			
LANDOI	AMILI CARL HOME LLC	GRIFTON,	NC 28530			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
C 370	Continued From page	÷ 54	C 370			
	the trash roll out cartShe did not think to d	contact the facility's to ask for guidance on how				
C 375	10A NCAC 13G .1009	9(a)(1) Pharmaceutical Care	C 375			
	10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to					
	prescribed and ensure effects, potential and or interactions, and m identified and reported prescribing practitione (B) making recomment necessary, based on outcomes and ensuring prescribing practitioned	d to the appropriate er; and, ndations for change, if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			
		FCL074050	B. WING		02	2/09/2024
	ROVIDER OR SUPPLIER	6347 FA	ADDRESS, CITY, STATE IRWAY DRIVE N, NC 28530	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 375	review in the resident This Rule is not met Based on record reviews were comple residents (#2, #3). The findings are: 1. Review of Resident 01/16/23 revealed:	as evidenced by: ews and interviews, the e quarterly pharmacy ted for 2 of 3 sampled	C 375			
	-Diagnoses included type 2 diabetes and hypertension. -There was an order for Jardiance (a medication used to control high blood sugar) 25 mg daily. -There was an order for Therems-M tablet (a multivitamin with iron) daily. -There was an order for Lisinopril (a medication used to treat high blood pressure) 2.5mg daily. -There was an order for Cerovite Senior (a multi-vitamin) daily. -There was an order for Glipizide (a medication used to control high blood sugar) 5mg twice daily. -There was an order for Metformin (a medication used to control high blood sugar) 1000mg twice daily. -There was an order for Atorvastatin (a medication used to lower cholesterol) 40mg at					
	nightThere was an order used to treat pain and every 4 hours as nee	for Tylenol (a medication d/or fever) 325mg, 2 tablets ded. 2's Resident Register litted to the facility 08/30/17.				

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		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	COMPLETED		
	FCL074050	B. WING		02/09/2024	
ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	6347 FAIR	WAY DRIVE			
AMILY CARE HOME LLC	GRIFTON,	NC 28530			
		ID		(- /	
,		PREFIX TAG	,		
Continued From page	e 56	C 375			
on 10/23/23.	* * * * * * * * * * * * * * * * * * * *				
Refer to interview with 02/09/24 at 4:39pm.	h the Administrator on				
2. Review of Resident #3's current FL-2 dated 03/03/23 revealed diagnosis included schizophrenia.					
revealed:					
on10/24/23.	·				
quarterly pharmacy re -There was a previou	eview.				
dated 07/12/23.					
Refer to interview with the Administrator on 02/09/24 at 4:39pm.					
4:39pm revealed: -Previously a Registe contracted through th	ered Nurse (RN) was e facility's pharmacy to				
pharmacy reviewsThe RN left that posi	ition and the Administrator				
	ROVIDER OR SUPPLIER FAMILY CARE HOME LLC SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page -The most recent qua on 10/23/23There was no docum pharmacy review had 10/23/23. Refer to interview wit 02/09/24 at 4:39pm. 2. Review of Resident # revealed he was adm 11/12/19. Review of Resident # revealed: -The last quarterly revon10/24/23There was no docum quarterly pharmacy review as a previou dated 07/12/23. Refer to interview wit 02/09/24 at 4:39pm. Interview with the Add 4:39pm revealed: -Previously a Register contracted through the come to the facility ar pharmacy reviewsThe RN left that positive revolutions of the page 12 pharmacy reviewsThe RN left that positive revolutions of the page 12 pharmacy reviewsThe RN left that positive reviews.	FCL074050 ROVIDER OR SUPPLIER STREET ADD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 56 -The most recent quarterly pharmacy review was on 10/23/23There was no documentation that a quarterly pharmacy review had been completed after 10/23/23. Refer to interview with the Administrator on 02/09/24 at 4:39pm. 2. Review of Resident #3's current FL-2 dated 03/03/23 revealed diagnosis included schizophrenia. Review of Resident #3's Resident Register revealed he was admitted to the facility on 11/12/19. Review of Resident #3's record on 02/08/24 revealed: -The last quarterly review was completed on10/24/23There was no documentation of a current quarterly pharmacy reviewThere was a previous quarterly pharmacy review dated 07/12/23. Refer to interview with the Administrator on 02/09/24 at 4:39pm. Interview with the Administrator on 02/09/24 at 4:39pm revealed: -Previously a Registered Nurse (RN) was contracted through the facility's pharmacy to come to the facility and complete the quarterly	ROVIDER OR SUPPLIER FCL074050 ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STA 6347 FAIRWAY DRIVE GRIFTON, NC 28530 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 56 -The most recent quarterly pharmacy review was on 10/23/23. -There was no documentation that a quarterly pharmacy review had been completed after 10/23/23. Refer to interview with the Administrator on 02/09/24 at 4:39pm. 2. Review of Resident #3's current FL-2 dated 03/03/23 revealed diagnosis included schizophrenia. Review of Resident #3's Resident Register revealed he was admitted to the facility on 11/12/19. Review of Resident #3's record on 02/08/24 revealed: -The last quarterly review was completed on10/24/23There was no documentation of a current quarterly pharmacy reviewThere was a previous quarterly pharmacy review dated 07/12/23. Refer to interview with the Administrator on 02/09/24 at 4:39pm. Interview with the Administrator on 02/09/24 at 4:39pm revealed: -Previously a Registered Nurse (RN) was contracted through the facility's pharmacy to come to the facility and complete the quarterly pharmacy reviewsThe RN left that position and the Administrator	ROVIDER OR SUPPLIER FCL074050 STREET ADDRESS, CITY, STATE, ZIP CODE 6347 FAIRWAY DRIVE GRIFTON, NC 28530 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPH DEFICIENCY) COntinued From page 56 The most recent quarterly pharmacy review was on 10/23/23. There was no documentation that a quarterly pharmacy review what been completed after 10/23/23. 2. Review of Resident #3's current FL-2 dated 03/03/23 revealed diagnosis included schizophrenia. Review of Resident #3's Resident Register revealed he was admitted to the facility on 11/12/19. Review of Resident #3's record on 02/08/24 revealed: The last quarterly review was completed on 10/24/23. There was no documentation of a current quarterly pharmacy review. There was a previous quarterly pharmacy review dated 07/12/23. Refer to interview with the Administrator on 02/09/24 at 4:39pm. Refer to interview with the Administrator on 02/09/24 at 4:39pm. Refer to interview with the Administrator on 02/09/24 at 4:39pm. The rewas no documentation of a current quarterly pharmacy review. There was a previous quarterly pharmacy review dated 07/12/23. Refer to interview with the Administrator on 02/09/24 at 4:39pm. Refer to interview with the Administrator on 02/09/24 at 4:39pm. Fine revealed: Freviously a Registered Nurse (RN) was contracted through the facility's pharmacy to come to the facility spharmacy to come to the facility and complete the quarterly pharmacy reviews. Fine RN left that position and the Administrator	

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