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	FCL074050	A. BUILDING: _____ B. WING _____	02/09/2024

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a complaint investigation from February 8, 2024 to February 9, 2024.	C 000		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F for 3 of 3 fixtures sampled, including 2 sinks and a tub that were readily accessible and used by residents with hot water temperatures ranging from 94 degrees F to 96.5 degrees F. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of up to 6 ambulatory residents. Review of the facility's current resident list provided on 02/08/24 revealed the facility's current census was 6 residents. Observation of the hot water temperatures in a bathroom that male residents shared on 02/08/24	C 105		

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C 105	Continued From page 1 at 8:50am revealed: -The hot water temperature in the sink was 95 degrees F. -The hot water temperature in the tub was 95.6 degrees F. Observation of the hot water temperatures in a bathroom that female residents shared on 02/08/24 at 8:55am revealed the hot water temperature in the sink was 94 degrees F. 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 ago. -The resident's only concern about the facility was that the water in her shower was too cold. -She thought the water was around 80 to 90 degrees Fahrenheit. -She had skipped taking showers a couple of times because the water was too cold. Observation of the hot water temperatures in a bathroom that male residents shared on 02/09/24 at 4:01pm with the Administrator revealed: -The Administrator filled ¼ of the bathroom sink with water and submerged a digital thermometer in the water. -The Administrator removed the digital thermometer from the bathroom sink and drained the water from the sink. -The Administrator used a probe dial thermometer to check the water temperature in the sink. -The Administrator and surveyor checked the water temperature in the sink.	C 105		

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C 105	Continued From page 2 -The Administrator's probe dial thermometer read 100 degrees F and the surveyors thermometer read 96 degrees F. -The Administrator and surveyor checked the water temperature in the tub. -The Administrator's probe dial thermometer read 100 degrees F and the surveyors thermometer read 96 degrees F. Observation of the hot water temperatures in the bathroom that female residents shared on 02/09/24 at 4:10pm revealed: -The Administrator and surveyor checked the water temperature in the sink. -The Administrator's probe dial thermometer read 100 degrees F and the surveyors thermometer read 94.5 degrees F. Interview with the Administrator on 02/09/24 at 4:15pm revealed: -She checked the water temperatures in both resident bathrooms every day when she provided residents assistance with bathing. -The water temperatures were 100 degrees F on 02/05/24 in the male resident's bathroom sink. -She was unable to locate a water temperature log for the facility, she thought it was in a storage box in a storage building outside. Telephone interview with the primary care provider (PCP) for residents at the facility on 02/09/24 at 12:47pm revealed: -Residents and staff needed water that was hot enough to practice appropriate infection control. -The facility needed the water to be a high enough temperature to kill germs and provide proper sanitation at the facility. -Residents dignity and comfort were affected when water temperatures were not hot enough for bathing.	C 105		

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C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure all staff were examined and screened for the presence of controlled substances upon hire and results were documented in the staff person's personnel file for 1 of 2 staff (B) sampled. The findings are: Review of Staff B's personnel record revealed: -There was no hire date documented. -Staff B's application date was 11/25/23. -Staff B was a Medication Aide (MA) and administered medications at the facility. -There was no documentation that an examination and screening for the presence of a controlled substance had been completed. Interview with the Administrator on 02/09/24 at 3:59pm revealed: -Staff B was hired on 11/25/23. -Staff B quit the position on 02/08/24 and was no longer employed at the facility. -She completed staff B's screen for controlled substances on 12/20/23. -She provided images of Staff B's negative test	C 148		

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C 148	Continued From page 4 results. -She was not aware the screen for controlled substances was required upon hire. Review of the images of Staff B's controlled substance test revealed: -The image was dated 12/20/23. -Staff B's initials were written on the top of a home drug test collection cup. -The image showed Staff B's negative test results.	C 148		
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 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. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the Resident Register was completed within 72 hours of admission to the facility for 1 of 3 sampled residents (#1). The findings are:	C 212		

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C 212	Continued From page 5 Review of Resident #1's current FL-2 dated 11/20/23 revealed diagnoses included bipolar disorder and vitamin D deficiency. 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, 2024. -She thought Resident #1 transferred about 2 weeks prior to the survey team's entrance on 02/08/24, but she was not sure what the actual transfer date was. -Resident #1 was initially admitted to the transferring facility on 11/01/23. -The transferring facility and current facility were owned and operated by the same owner and Administrator. -Resident #1's facility healthcare records and medications were included in the transfer and were continued at the current facility. Review of Resident #1's facility record on 02/08/24, revealed there was no Resident Register. Telephone interview with Resident #1's guardian on 02/09/24 at 8:10am revealed: -She completed the admission paperwork for Resident #1 when the resident was admitted to the transferring facility in November, 2023. -She gave the Administrator permission to transfer Resident #1 to the current facility on 01/13/24. -She had not completed any paperwork for the current facility. -The Administrator told her she would send the paperwork, but the guardian had not received anything from the facility.	C 212		

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C 212	Continued From page 6 Interview with the Administrator on 02/09/24 at 11:53am revealed she had not updated or completed a Resident Register since Resident #1 was transferred to the facility.	C 212		
C 214	10A NCAC 13G .0704 (a) Resident Contract And Information On Home 10A NCAC 13G .0704 Resident Contract And Information On Home The administrator or supervisor-in-charge shall furnish and review with the resident or his responsible person information on the family care home upon admission and when changes are made to that information. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given. This statement shall be retained in the resident's record in the home. The information shall include: (1) a copy of the home's resident contract specifying rates for resident services and accommodations, including the cost of different levels of service, if applicable, any other charges or fees, and any health needs or conditions the home has determined it cannot meet pursuant to G.S. 131D-2(a1)(4). In addition, the following applies: (a) The contract shall be signed and dated by the administrator or supervisor-in-charge and the resident or his responsible person and a copy given to the resident or his responsible person; (b) The resident or his responsible person shall be notified as soon as any change is known, but not less than 30 days for rate changes initiated by the home, of any rate changes or other changes in the contract affecting the resident services and	C 214		

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C 214	Continued From page 7 accommodations and be provided an amended copy of the contract for review and signature; (c) A copy of each signed contract shall be kept in the resident's record in the home; (d) Gratuities in addition to the established rates shall not be accepted; and (e) The maximum monthly rate that may be charged to Special Assistance recipients is established by the North Carolina Social Services Commission and the North Carolina General Assembly; Note: Facilities may accept payments for room and board from a third party, such as family member, charity or faith community, if the payment is made voluntarily to supplement the cost of room and board for the added benefit of a private room. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure admission contracts were completed and signed by the Administrator and the resident or resident's responsible person upon admission to the facility for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 11/20/23 revealed diagnoses included bipolar disorder and vitamin D deficiency. 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, 2024. -She thought Resident #1 transferred about 2 weeks prior to the survey team's entrance on	C 214		

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C 214	Continued From page 8 02/08/24, but she was not sure what the actual transfer date was. -Resident #1 was initially admitted to the transferring facility on 11/01/23. -The transferring facility and current facility were owned and operated by the same owner and Administrator. -Resident #1's facility healthcare records and medications were included in the transfer and were continued at the current facility. Review of Resident #1's facility record on 02/08/24, revealed: -There was no Resident Register. -The Resident Contract had not been completed when Resident #1 transferred to the current facility in January 2024.. Telephone interview with Resident #1's guardian on 02/09/24 at 8:10am revealed: -She completed the admission contract for Resident #1 when the resident was admitted to the transferring facility in November 2023. -She gave the Administrator permission to transfer Resident #1 to the current facility on 01/13/24. -She had not completed any paperwork for the current facility. -The Administrator told her she would send the paperwork, but the guardian had not received anything from the facility. Interview with the Administrator on 02/09/24 at 11:53am revealed she had not updated or completed the Resident Contract since Resident #1 was transferred to the facility.	C 214		
C 246	10A NCAC 13G .0902(b) Health Care	C 246		

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C 246	Continued From page 9 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE 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). The findings are: Review of the facility's health care policy dated 08/16/17 revealed: -The facility would provide care and services in accordance with the resident's care plan. -The facility would ensure that any referrals and follow up appointments needed to meet the resident's routine and severe health care needs would be completed. 1. Review of Resident #1's current FL-2 dated 11/20/23 revealed: -Diagnoses included bipolar disorder and vitamin D deficiency. -There was an order for lorazepam (a medication used to treat anxiety) 1mg at night.	C 246		

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Review of Resident #1's care plan dated 11/20/23 revealed the resident required limited assistance with eating, bathing, dressing, and grooming.

Review of Resident #1's primary care provider's (PCP) physician visit note dated 11/14/23 revealed:
-Resident #1 had a history of seizures.
-Resident #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 2024.
-The transferring facility and current facility were owned and operated by the same owner and Administrator.
-Resident #1's facility healthcare records and medications were included in the transfer and were continued at the current facility.
-At the time of the survey on 02/08/24, Resident #1 was hospitalized following a seizure 02/07/24.

a. Review of a hospital After Visit Summary dated 11/27/23 revealed:
-Resident #1 was admitted to the hospital on 11/26/23 for the evaluation and treatment of a seizure.
-Resident #1 was to follow-up with a neurosurgery specialist in 1-2 weeks.

Telephone interview with a Patient Access Representative at the neurosurgery specialist's office on 02/08/24 at 12:51pm revealed there was no record of a referral or appointment for Resident #1.

Telephone interview with Resident #1's guardian

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C 246	Continued From page 11 on 02/08/24 at 1:43pm revealed: -She was aware Resident #1 was hospitalized on 11/26/23, related to seizures. -Resident #1 did not have a current neurologist to manage her seizures. -She was not aware of the hospital After Visit Summary instructions for medication changes and she was not aware Resident #1 was to follow-up with the neurosurgery specialist. -The facility should have notified her of necessary follow-up appointments so that she could have assisted the facility in making sure the resident was seen by the specialists. Telephone interview with Resident #1's PCP on 02/09/24 at 12:47am revealed: -The facility was responsible for ensuring provider referrals were completed. -The facility notified her of Resident #1's hospitalization on 11/27/23. -The facility sent her a copy of the hospital After Visit Summary dated 11/27/23. -She was not aware Resident #1's referral to the neurosurgery specialist had not been made -The facility should have ensured Resident #1's referral to the neurosurgery specialist was completed. -It was important that Resident #1 followed up with the neurosurgery specialist for management of seizures because the resident had a history of seizures and complications related to seizure medications which previously contributed to a significant increase in mental health symptoms and behaviors. -Resident #1 had a history of severe agitation, aggression, and suicide attempts. Interview with the Administrator on 02/08/24 at 4:30pm revealed: -She notified Resident #1's PCP of Resident #1's	C 246		

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discharge from the hospital on 11/27/23.
-She sent the PCP a copy of the hospital After Visit Summary dated 11/27/23.
-She reviewed the hospital After Visit Summary dated 11/27/23, but she did not recall seeing the instructions for Resident #1 to follow-up with a neurosurgery specialist in 1-2 weeks.
-She thought the facility's referral process was PCP's, mental health providers or other providers completed any necessary referrals.
-Resident #1 had not been to an appointment with a neurosurgery specialist and she had not scheduled an appointment for Resident #1 to be seen by neurosurgery specialist.

Review of Resident #1's hospital records dated 11/26/23 revealed:
-The resident was sent to the hospital on 11/26/23, after she had 2 seizures over a 24-hour period.
-The resident did not remember the episodes.
-The resident was not oriented to time.

Review of Resident #1's hospital records dated 02/07/24 revealed:
-The resident was transported to the hospital by Emergency Medical Services (EMS) on 02/07/24, related to a witnessed seizure lasting 2 minutes that occurred at the facility.
-The resident was reported to have had 3 seizure episodes at the facility on 02/07/24 prior to admission to the hospital.
-The resident presented to the Emergency Department in a postictal state (altered state of consciousness after an epileptic seizure) with forehead swelling and confusion.
-The resident was admitted to the hospital for treatment of breakthrough seizures.

b. Telephone interview with Resident #1's PCP on

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C 246	Continued From page 13 02/09/24 at 12:47am revealed: -The facility was responsible for ensuring residents' appointments were scheduled and attended. -Her most recent visit with Resident #1 was on 11/14/23, when the resident was living in another facility. -She was not notified that Resident #1 had moved to the current facility in January 2024 until the Administrator called her on 02/08/24. -Resident #1 was scheduled for a follow-up tele health appointment with the PCP on 01/08/24. -The Administrator canceled Resident #1's follow-up appointment with the PCP on 01/08/24. -The Administrator canceled Resident #1's rescheduled follow-up appointments with the PCP on 01/09/24 and 01/10/24. -Because of Resident #1's recent hospitalization and history of seizures it was important that resident attended all follow-up appointments. Interview with the Administrator on 02/08/24 at 4:30pm revealed she did not recall canceling or rescheduling Resident #1's appointments with her PCP. 2. Review of Resident #3's current FL-2 dated 03/03/23 revealed: -Diagnosis included schizophrenia. -The resident was ambulatory, and the orientation status was not documented. -The resident's level of care was other. Review of Resident #3's care plan dated 02/27/23 revealed: -He required extensive assistance with eating, bathing, and grooming. -He required limited assistance with toileting and dressing.	C 246		

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L AND C FAMILY CARE HOME LLC	6347 FAIRWAY DRIVE GRIFTON, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 14 Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 11/12/19. Telephone interview with Resident #3's primary care provider (PCP) on 02/09/24 at 12:47pm revealed: -Resident #3 was seen via telehealth on 01/06/24 for a swollen area on the right side of his jaw. -The resident was prescribed an antibiotic, and she scheduled a follow up telehealth appointment for 01/08/24. -She received a text message from the Administrator on 01/08/24 that Resident #3 was unable to keep his appointment because she had been busy, and she was sorry she missed the resident's appointment. -The PCP scheduled a follow up appointment for Resident #3 on 01/09/24 via telehealth. -The Administrator canceled the telehealth appointment for Resident #3 on 01/09/24 by text message. -The PCP called the Administrator on 02/02/24 to schedule a follow up appointment with Resident #3. -The Administrator informed the PCP on 02/02/24 that she would call her back 02/05/24 to schedule an appointment for Resident #3. -The Administrator had not contacted her for a follow up appointment with Resident #3 until 02/08/24. -The Administrator sent her a text message on 02/08/24 and asked if she would like to see Resident #3 on 02/08/24 at 3:30pm. Interview with the Administrator on 02/09/24 at 4:30pm revealed: -She always notified the Resident #3's PCP of any issues or concerns that she had for the	C 246		

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C 246	Continued From page 15 resident. -She had not canceled any appointments with the PCP for Resident #3. -She could not remember why Resident #3 missed his telehealth appointment with the PCP to follow up on the lump on his jaw. -Resident #3's lump on his jaw improved after he took the antibiotic his PCP prescribed. Attempted interview with Resident #3 on 02/09/24 at 8:23am was unsuccessful. _____ The facility failed to ensure Resident #1, who was hospitalized 11/26 through 11/27 for breakthrough seizures, was referred to a neurosurgery specialist and failed to ensure the resident was seen by the PCP after the Administrator canceled three follow-up appointments. The resident was admitted to the hospital again on 02/07/24 for the evaluation and treatment of breakthrough seizures. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 10, 2024.	C 246		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:	C 315		

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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 deficiency. -There was an order for lorazepam (an anti-anxiety medication) 1mg at night. Review of Resident #1's primary care provider's (PCP) physician visit note dated 11/14/23 revealed: -Resident #1 had a history of seizures. -Resident #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 2024. -Resident #1 was initially admitted to the	C 315		

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C 315	Continued From page 17	C 315		

transferring facility on 11/01/23.
-The transferring facility and current facility were owned and operated by the same owner and Administrator.
-Resident #1's facility healthcare records and medications were included in the transfer and were continued at the current facility.
-There was no record showing what medications Resident #1 admitted or transferred with.
-At the time of the survey on 02/08/24, Resident #1 was hospitalized following a seizure on 02/07/24.

Review of a hospital After Visit Summary dated 11/27/23 revealed:
-Resident #1 was hospitalized 11/26/23 through 11/27/23 for the evaluation and treatment of seizures.
-Resident #1 was to stop taking lorazepam 1mg.
-Resident #1 was to start taking temazepam (a medication used for the treatment of insomnia) 30mg at night.

Review of Resident #1's MARs dated 01/13/24 through 02/08/24 revealed:
-There was not an entry for lorazepam.
-There was no entry for temazepam.

Observations of Resident #1's medications on hand on 02/08/24 at 4:06pm revealed:
-The facility had one bubble pack card for lorazepam 1mg every night for Resident #1.
-There were 13 pills remaining in the bubble pack.
-The pharmacy label showed 30 tablets of lorazepam 1mg dispensed 11/27/23.
-Temazepam was not on hand in Resident #1's medications.

Telephone interview with a pharmacist with the

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C 315	Continued From page 18 facility's contracted pharmacy on 02/09/24 at 8:43am revealed: -Resident #1 was admitted to their services on 11/02/23. -Resident #1 was ordered lorazepam 1mg each night for sleep/anxiety on 11/02/23. -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 facility for Resident #1. -On 11/27/23 at 2:44pm, the facility faxed the hospital After Visit Summary dated 11/27/23, that included orders for Resident #1 to stop taking lorazepam and start taking temazepam 30mg. -The pharmacy placed a stop on the lorazepam. -The pharmacy was not able to fill the order for temazepam because the hospital After Visit Summary did not include all required information. -According to pharmacy records there was no current order for Resident #1 to receive lorazepam or temazepam. -According to the current medication orders at the pharmacy, Resident #1 should have had 30 of 30 tablets in the pharmacy bubble pack. -The facility should not have administered lorazepam after 11/27/23 because according to pharmacy records 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 psychotropic medications and completed monthly visits on 11/07/23 and 01/12/24. -Resident #1 had orders for lorazepam 1mg each night, for anxiety and sleep when the resident admitted to the previous facility on 11/02/23.	C 315		

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-Resident #1 had current orders for lorazepam 1mg each night.
-She had not changed or discontinued the lorazepam and thought Resident #1 had been administered lorazepam each night 11/02/23 through 02/07/24.
-She was aware of Resident #1's hospitalization for seizures 11/26/23 through 11/27/23.
-She was not aware of the hospital After Visit Summary instructions for Resident #1 to stop taking lorazepam 1mg and start taking temazepam.
-The facility contacted her on 11/27/23 and requested she send a signed prescription for lorazepam to Resident #1's pharmacy, but the facility did not mention the hospital After Visit Summary.
-On 11/27/23, she sent the signed prescription to the pharmacy for Resident #1 to continue lorazepam 1mg every night.
-She was concerned the facility had not notified her of the medication changes included in the hospital After Visit Summary because Resident #1 required medications to help stabilize her mental health and behaviors and the resident was prescribed numerous psychotropic medications that could have side effects and interactions.
-Side effects and possible interactions if Resident #1's psychotropic medications were not administered as ordered included increased lethargy, dizziness, increased risk for falls, increased mental health symptoms and behaviors including agitation and difficulty sleeping.

Interview with the Administrator on 02/09/24 at 11:53am revealed:
-She reviewed the After Visit Summary dated 11/27/23 and sent it to the pharmacy on 11/27/23.
-She contacted Resident #1's mental health provider on 11/27/23, to clarify the orders for

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C 315	Continued From page 20 lorazepam and temazepam and she notified the mental health provider that the pharmacy needed a new prescription for lorazepam. -The mental health provider sent the pharmacy an order for Resident #1's lorazepam on 11/27/23. -She thought the mental health provider had clarified she wanted Resident #1 to continue lorazepam and not start temazepam with the pharmacy.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to administer medications in accordance with physician orders for 2 of 3 sampled residents (#1 and #3) including orders for psychotropic medications (#1) and a medication to treat anxiety (#3). The findings are: Review of the facility's medication administration policy dated 08/16/17 revealed: -The facility would ensure the preparation and	C 330		

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administration of medications, prescriptions and non-prescriptions, and treatments by staff are in accordance with state law and licensing.
-The recording of the administration of medications on the medication administration record should be recorded by the staff person who administers the medication.
-The staff person should document the administration of medication immediately following administration of the medication.
-The staff person should observe the resident actually taking the medication.

1. Review of Resident #1's current FL-2 dated 11/20/23 revealed:
-Diagnoses included bipolar disorder and vitamin D deficiency.
-There was an order for lorazepam (a benzodiazepine medication used for the treatment of anxiety) 1mg at night.

Review of Resident #1's primary care provider's (PCP) physician visit note dated 11/14/23 revealed:
-Resident #1 had a history of seizures.
-Resident #1 had a diagnosis of neurocognitive disorder and her memory and processing were impaired.

Review of Resident #1's signed medication orders revealed:
-There was an order dated 11/27/23 for lorazepam 1mg at night.
-The order was electronically signed by Resident #1's mental health provider.

Review of a hospital After Visit Summary dated 11/27/23 revealed:
-Resident #1 was hospitalized 11/26/23 through 11/27/23 for the evaluation and treatment of

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seizures.
-Resident #1 was to stop taking lorazepam 1mg.
-Resident #1 was to start taking temazepam (a benzodiazepines medication used for the treatment of insomnia) 30 mg at night.

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 2024.
-The transferring facility and current facility were owned and operated by the same owner and Administrator.
-Resident #1's facility healthcare records and medications were included in the transfer and were continued at the current facility.
-At the time of the survey on 02/08/24, Resident #1 was hospitalized following a seizure 02/07/24.

Review of Resident #1's medication administration records (MARs) dated 01/01/24 through 02/08/24 revealed:
-There was not an entry for lorazepam.
-There was not an entry for temazepm.

Observations of Resident #1's medications on hand on 02/08/24 at 4:06pm revealed:
-The facility had one bubble pack card for lorazepam 1mg every night for Resident #1.
-There were 13 pills remaining in the bubble pack.
-The pharmacy label showed 30 tablets of lorazepam 1mg dispensed on 11/27/23.
-There was no temazepam on hand for Resident #1.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 02/09/24 at 8:43am revealed:
-The pharmacy provided MARs to the facility

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C 330	Continued From page 23 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, that 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 pharmacy's current medication orders and dispensing records, Resident #1 should have had 30 of 30 tablets of lorazepam 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 records 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 psychotropic medications and completed monthly visits on 11/07/23 and 01/12/24. -Resident #1 had current orders for lorazepam 1mg each night.	C 330		

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C 330	Continued From page 24 -During her visits on 11/07/23 and 01/12/24 she recommended to continue Resident #1's medication orders which included lorazepam 1mg each night. -She had not changed or discontinued the lorazepam and thought Resident #1 had been administered lorazepam each night 11/02/23 through 02/07/24. -She was aware of Resident #1's hospitalization for seizures 11/26/23 through 11/27/23. -She was not aware of the hospital After Visit Summary instructions for Resident #1 to stop taking lorazepam 1mg and start taking temazepam 30mg. -The Administrator contacted her on 11/27/23 and requested she send a signed prescription for lorazepam to Resident #1's pharmacy, but the Administrator did not mention the hospital After Visit Summary. -On 11/27/23, she sent the signed prescription to the pharmacy for Resident #1 to continue lorazepam 1mg every night. -On 01/19/24 the Administrator contacted her because Resident #1 had increased agitation and difficulty sleeping. -On 01/19/24, she added an order for Seroquel (an anti-psychotic medication) 50mg at night for sleep, related to the resident's reported agitation and difficulty sleeping. -She was not aware the medication on hand for Resident #1 showed 13 of 30 tablets, dispensed on 11/27/23, were not administered to Resident #1. -She was concerned the facility had not administered Resident #1's psychotropic medications according to physician orders because Resident #1 required medications to help stabilize her mental health and behaviors and the resident was prescribed numerous psychotropic medications that could have side	C 330		

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effects and interactions.
-Side effects and possible interactions if Resident #1's psychotropic medications were not administered as ordered included increased lethargy, dizziness, increased risk for falls, increased mental health symptoms and behaviors including agitation and difficulty sleeping.
-Abruptly stopping a benzodiazepine medication could have increased the risk of lowering the seizure threshold (increased risk of seizures).
-Complications of seizures could include serious injuries, increased risk of falls, difficulty breathing and confusion.

Telephone interview with Resident #1's PCP on 02/09/24 at 12:47am revealed:
-She was not aware Resident #1 was not administered psychotropic medications according to the mental health provider's orders.
-It was important for Resident #1's medications to be administered correctly because the resident had a history of seizures, agitation, aggression and suicide attempts and changes in her medications could contribute to an increase in those symptoms.

Review of Resident #1's hospital records dated 02/07/24 revealed:
-The resident was transferred to the hospital by Emergency Medical Services (EMS) related to a witnessed seizure lasting 2 minutes at the facility
-The resident was reported to have had 3 seizure episodes at the facility on 02/07/24, prior to being transferred to the hospital.
-The resident presented to the Emergency Department in a postictal state (altered state of consciousness after an epileptic seizure) with forehead swelling and confusion.
-The resident was admitted to the hospital for treatment of breakthrough seizures.

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C 330	Continued From page 26 Interview with the Administrator on 02/09/24 at 11:53am revealed: -When she or the MA's administered medications they were to verify that the order on the MAR matched the pharmacy label on the bubble pack before they administered the medications and then document the administration on MAR. -She completed weekly audits of the MARs and medications on hand. -She reviewed the After Visit Summary dated 11/27/23 and sent it to the pharmacy on 11/27/23. -She contacted Resident #1's mental health provider on 11/27/23, to clarify the orders for lorazepam and temazepam and she notified the mental health provider that the pharmacy needed a new prescription for lorazepam. -The mental health provider sent the pharmacy an order for Resident #1's lorazepam on 11/27/24. -There was no log that showed Resident #1's lorazepam was dispensed to the facility on 11/27/23. -She did not know why there were 13 of 30 tablets of lorazepam 1mg remaining in Resident #1's medication bubble pack. -It was important for medications to be administered according to the physician's orders for the health of the residents. -She completed weekly audits of Resident #1's medications but did not know how she missed the error for Resident #1's lorazepam. -She was not aware that if a benzodiazepine medication was abruptly stopped it could increase the risk of seizures. 2. Review of Resident #3's current FL-2 dated 03/03/23 revealed: -Diagnosis included schizophrenia.	C 330		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 27 -There was an order for Klonopin 1mg, take 3 tablets (3mg) every evening (Klonopin is used to treat anxiety). Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 11/12/19. Review of Resident #3's December 2023 medication administration record (MAR) revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 12/01/23 to 12/31/23. Review of Resident #3's January 2024 MAR revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 01/01/24 to 01/31/24. Review of Resident #3's February 2024 MAR revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 02/01/24 to 02/06/24. Observation of medications on hand on 02/08/24 at 4:49pm revealed there was a bubble pack medication card with a fill date of 01/05/24, with 21 Klonopin 1mg tablets, a 7 day supply available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/09/24 at	C 330		

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	FCL074050	A. BUILDING: _____ B. WING _____	02/09/2024

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C 330	Continued From page 28 10:19am revealed: -90 Klonopin 1mg tablets were dispensed for Resident #3 on 12/09/23; a 30 day supply. -90 Klonopin 1mg tablets were dispensed for Resident #3 on 01/05/24, a 30 day supply. Telephone interview with Resident #3's psychiatrist on 02/09/24 at 10:00am revealed: -Resident #3 had a history of hallucinations and delusions. -Klonopin helped the resident have less hallucinations and delusions. -When Resident #3 was not administered his Klonopin as prescribed he had increased confusion, agitation, anxiety, insomnia, and restlessness. -If Resident #3 was not administered his Klonopin as ordered, he would have increased hallucinations and delusions, and she would need to adjust the antipsychotic he was prescribed. Telephone interview with Resident #3's primary care provider (PCP) on 02/09/24 at 12:47pm revealed: -Resident #3 was prescribed Klonopin to help control his anxiety, hallucinations, and delusions. -Resident #3 was at risk of increased delusions, hallucinations, anxiety, agitation, insomnia, and a decreased appetite if he did not receive his Klonopin every evening at 8:00pm. Interview with the Administrator on 02/09/24 at 11:48am revealed: -She administered Resident #3 Klonopin 1mg, 3 tablets (3mg) every evening before bedtime. -Resident #3 had never been out of his prescribed medications. -If Resident #3 did not receive his medications as ordered he acted very immature, played in the toilet, and put objects in his ears and nose.	C 330		

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C 330	Continued From page 29 -The resident had not had any behavioral issues in the past six months and had received his Klonopin every night at bedtime. -She could not explain why Resident #3 had a 7 day supply of Klonopin on hand. _____ The facility failed to ensure Resident #1, who had a history of seizures, agitation and suicide attempts, was administered her psychotropic medications according to physician's orders placed the resident at risk of experiencing side effects and/or medication interactions, abruptly stopping Resident #1's lorazepam placed the resident at an increased risk for serious injury related to seizures and the resident was hospitalized for seizures on 02/07/24. Resident #3 who had a diagnosis of schizophrenia was not administered his medication used to prevent an increase in in hallucinations, delusions, anxiety, agitation, and insomnia. This failure resulted in substantial risk for serious harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 10, 2024.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to	C 335		

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C 335	Continued From page 30 the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications that were prepared for administration in advance were stored in a sealed container to protect the medication from contamination or spillage and the storage container was labeled to identify the name of the resident and name and strength of the medication for 1 of 3 sampled residents (#1).	C 335		

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C 335	Continued From page 31 The findings are: Review of the facility's medication administration policy on 02/09/24 revealed: -The policy was dated 03/2017. -The facility did not allow staff to pre-pour medications. -All medications were to remain in their original packaging until they reached the client. Review of Resident #1's current FL-2 dated 11/20/23 revealed diagnoses included bipolar disorder and vitamin D deficiency. 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, 2024. -Resident #1 was initially admitted to the transferring facility on 11/01/23. -The transferring facility and current facility were owned and operated by the same owner and Administrator. -Resident #1's facility healthcare records and medications were included in the transfer and were continued at the current facility. -At the time of the survey on 02/08/24, Resident #1 was hospitalized following a seizure on 02/07/24. Review of Resident #1's medication orders revealed: -There was an order for risperidone 2mg, 1.5 tablets twice daily, dated 12/09/24. -There was an order for trazodone 50mg at night, dated 11/20/23. -There was an order for lamotrigine 150mg twice daily, dated 12/09/23. -There was an order for quetiapine 50mg at night,	C 335		

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C 335	Continued From page 32 dated 01/19/24. -There was an order for lorazepam 1mg at night dated, 11/27/23. Observations of Resident #1's medications on hand on 02/08/24 at 4:06pm revealed: -There was a bubble pack, with 10 of 30 doses remaining, was labeled with a with a pharmacy label that read risperidone tablet 2mg, take 1 &1/2 tablets 1.5 tablets twice daily, dispensed on 01/13/24. -There was a bubble pack, with 27 of 30 doses remaining, that was labeled with a pharmacy label that read trazodone 50mg at night dispensed on 01/28/24. -There was a bubble pack, with 17 of 30 doses remaining, that was labeled with a pharmacy label that read lamotrigine 150mg twice daily. Dispensed on 01/15/24. -There was a bubble pack, with 11 of 30 doses remaining, that was labeled with a pharmacy label that read quetiapine 50mg at night, dispensed on 01/19/24. -There was a bubble pack, with 13 of 30 doses remaining, that was labeled with a pharmacy label that read lorazepam 1mg at night, dispensed on 11/27/23. Observations of the facility's medication storage cart on 02/09/24 at 12:39pm revealed: -There was a medication cup with Resident #1's initial's written on the side. -The cup contained 2 round white tablets and 1 six sided yellow tablet.. -The cup was stored in the top drawer of the medication cart. -The top drawer of the medication cart contained rubber-bands, pens, markers, scissors, a stapler, a pair of medical gloves and laminated paperwork.	C 335		

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C 335	Continued From page 33	C 335		

-The cup was not covered or sealed to prevent contamination.
-The cup was not labeled with the resident's name or name and strength of each medication in the cup.

Observation of the Administrator on 02/09/24 at 12:15pm revealed:
-The Administrator brought three medication cups that belonged to Resident #1 to the dining room table.
-There were initials on the side of each medication cup written in black, the initials belonged to Resident #1.
-There were two cups that contained tablets.
-Both cups contained one white round tablet with an F84 printed in black on one side of the tablet, one white round tablet with 1330 imprinted on one side of the tablet, one yellow six sided tablet with D95 imprinted on one side of the tablet, one round yellow tablet with RI4 imprinted on one side of the tablet, and one half of one round yellow tablet with RI4 imprinted on one side of the tablet.
-The third medication cup contained one six-sided beige tablet with D95 imprinted on one side of the tablet, one round yellow tablet with RI4 imprinted on one side of the tablet, and one half of one round yellow tablet with RI4 imprinted on one side of the tablet.

Interview with the Administrator on 02/09/24 at 12:29pm revealed:
-She did not know why the medications were stored in the medication cart in a cup that was not sealed or labeled.
-She thought the medication aide (MA) may have prepared the medications for administration but did not administer the medications before Resident #1 was sent to the hospital on 02/07/24.
-The MA who prepared Resident #1's

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C 335	Continued From page 34 medications was no longer employed at the facility as of 02/08/24.	C 335		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records (MAR) for 1 of 3 sampled residents (#3). The findings are: Review of the facility's medication administration policy dated 08/16/17 revealed:	C 342		

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C 342	Continued From page 35 -The facility should ensure the preparation and administration of medications, prescriptions and non-prescriptions, and treatments by staff are in accordance with state law and licensing. -The recording of the administration of medications on the medication administration record should be recorded by the staff person who administers the medication. -The staff person should document the administration of medication immediately following administration of the medication. -Staff should observe a resident take their medications prior to the administration of a different resident's medication, pre-charting is prohibited. -The resident's medication administration record (MAR) should be accurate and include the resident's name, name of medication, strength and dosage or quantity of medication administered, instructions for administering the medication, reason or justification for the administration of medications as needed and documenting the resulting effect on the resident, date and time of administration, documentation of any omission of medication and the reason for the omission including refusals, and the name or initials of the person administering the medication, if initial are used, a signature equivalent to those initials should be documented and maintained with the MAR. Review of Resident #3's current FL-2 dated 03/03/23 revealed: -Diagnosis included schizophrenia. -There was an order for Klonopin 1mg, take 3 tablets (3mg) every evening (Klonopin is used to treat anxiety and seizures). Review of Resident #3's Resident Register revealed the resident was admitted to the facility	C 342		

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C 342	Continued From page 36 on 11/12/19. Review of Resident #3's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 12/01/23 to 12/31/23. Review of Resident #3's January 2024 eMAR revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 01/01/24 to 01/31/24. Review of Resident #3's February 2024 eMAR revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 02/01/24 to 02/06/24. Observation of medications on hand on 02/08/24 at 4:49pm revealed there were 21 Klonopin 1mg tablets, a 7 day supply available for administration. Review of Resident #3's January 2024 controlled substance record (CSR) revealed: -There was a CSR secured to the back of Resident #3's Klonopin bubble card with a rubber band. -The CSR had a printed label from the facility's contracted pharmacy with Klonopin 1mg, take 3 tablets (3mg) every evening, a dispensing date of	C 342		

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C 342	Continued From page 37 01/05/24, and a quantity of 90 tablets. -The CSR had a space for staff to sign if they administered the medication, the date and time the medication was administered, the amount given and the amount of the Klonopin remaining. -The CSR was blank. Attempted interview with Resident #3 on 02/09/24 at 02/09/24 at 8:23am was unsuccessful. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/09/24 at 10:19am revealed: -90 Klonopin 1mg tablets were dispensed for Resident #3 on 12/09/23; a 30 day supply. -90 Klonopin 1mg tablets were dispensed for Resident #3 on 01/05/24, a 30 day supply. Telephone interview with Resident #3's psychiatrist on 02/09/24 at 10:00am revealed: -Klonopin helped the resident have less hallucinations and delusions. -When Resident #3 was not administered his Klonopin as prescribed he had increased confusion, agitation, anxiety, insomnia, and restlessness. -If Resident #3 was not administered his Klonopin as ordered, he would have increased hallucinations and delusions, and she would need to adjust the antipsychotic he was prescribed. Telephone interview with Resident #3's primary care provider (PCP) on 02/09/24 at 12:47pm revealed: -Resident #3 was prescribed Klonopin to help control his anxiety, hallucinations, and delusions. -Resident #3 was at risk of increased delusions, hallucinations, anxiety, agitation, insomnia, and a decreased appetite if he did not receive his Klonopin every evening at 8:00pm.	C 342		

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C 342	Continued From page 38 Interview with the Administrator on 02/09/24 at 11:48am revealed: -She completed medication audits every week which included comparing the resident's physician orders, the MAR, and medications on hand. -She or the medication aide (MA) administered Resident #3 Klonopin 1mg, 3 tablets (3mg) every evening before bedtime. -The MA evidently made mistakes on the MARs and documented she administered the resident Klonopin every evening when the resident did not receive his Klonopin every evening, that was the only way she was able to understand how the resident had a 7 day supply of Klonopin available. Attempted interview with Resident #3 on 02/09/24 at 02/09/24 at 8:23am was unsuccessful.	C 342		
C 365	10A NCAC 13G .1007(e) Medication Disposition 10A NCAC 13G .1007 Medication Disposition (e) Records of medications destroyed or returned to the pharmacy shall include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the pharmacist, dispensing practitioner or their designee. These records shall be maintained by the facility for a minimum of one year. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to return medications for 1 of 4 sampled residents to the facility's	C 365		

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C 365	Continued From page 39 contracted pharmacy after a resident was discharged (#4). The findings are: Review of the facility's medication disposition policy dated 08/16/17 revealed: -When residents are discharged, medications should be released to go with the resident, if the resident has a physician order to continue the medication. -Prescribed medications are the property of the resident and should not be given to, or taken by, other staff or residents. -Medications, excluding controlled medications, should be destroyed at the facility, or returned to the pharmacy within 90 days of expiration or discontinuation of the medication or following the death of a resident. -All medication destroyed at the facility should be destroyed by the Administrator and witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. -The destruction should be conducted so that no person can use, administer, sell, or give away the medication. -Records of medications destroyed or returned to the pharmacy will include the resident's name, the name and strength of the medication, the amount destroyed or returned, the method of destruction if destroyed in the facility and the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. -These records should be maintained by the facility for a minimum of one year. -Discontinued medications should be removed from their original containers.	C 365		

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C 365	Continued From page 40 -Scratch out or remove all identifying information on the prescription label on the original container to protect the identity of the resident. -Place the medications in an impermeable, non-descript container such as a coffee can, and mix with water or coffee to dissolve the medications. -Mix with an undesirable substance such as used coffee grounds so the medications will be less appealing and unrecognizable to people who may intentionally go through the facility's trash. -Tightly seal the container and throw it away. Review of Resident #4's current FL-2 dated 11/20/23 revealed: -Diagnoses of pulmonary embolism, seizure, major depressive disorder, chronic obstructive pulmonary disease (COPD), and intellectual disability. -There was an order for Pantoprazole 40mg, take one tablet every day at 8:00am (Pantoprazole is used to treat heartburn). -There was an order for Lamotrigine 25mg, take one tablet every day at 8:00am (Lamotrigine is a medication used to control seizures). -There was an order for Escitalopram 10mg, take one tablet every day at 8:00am (Escitalopram is used to treat depression). -There was an order for Carbamazepine 200mg, take one tablet daily at 8:00am and 8:00pm (Carbamazepine is used to treat epilepsy). -There was an order for Meloxicam 15mg, take one tablet at 8:00am as needed (Meloxicam is used to treat symptoms of arthritis). -There was an order for Phenobarbital 32.4mg, take one tablet daily at 8:00am and 8:00pm (Phenobarbital is a controlled substance used to treat seizures). Interview with the Administrator on 02/08/24 at	C 365		

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C 365	Continued From page 41 11:30am revealed: -Resident #4 was discharged on 12/09/23 when a family member came to pick him up from the facility. -The family member forgot to take the resident's medications with her when she left the facility with Resident #4. -She spoke with the family member by telephone approximately 15 minutes after the resident left with his family member and asked the family member to return to the facility to pick up the resident's medications. -The family member did not return to pick up Resident #4's medications. -She threw Resident #4's medications away a few days after the resident's family did not return to get the resident's medications. -She placed the resident's medications in a plastic bag, tied the bag, and placed the plastic bag in the roll out trash can that goes to the street to be picked up weekly. -She did not have a system in place to document the medications and quantity of medications she disposed of; she did not think to contact the facility's contracted pharmacy to ask about returning the medications to the pharmacy. Observations of medications on hand on 02/08/24 at 4:51pm revealed there were no medications for Resident #4 available for administration. Observation of the facility's front porch on 02/08/24 at 8:15am revealed there was a locked secured box for the pharmacy to deliver medications to the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/08/24 at 2:56pm revealed: -The pharmacy had a contract with the facility	C 365		

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C 365	Continued From page 42 which included a process for the facility to appropriately return medications to the pharmacy. -The facility should have contacted the pharmacy to inform that Resident #4 had medications that needed to be returned. -The pharmacy would create a label to set up the return process, and the driver for the pharmacy that would drop off medications would retrieve the resident's medications from a locked box on the facility's front porch. -The facility should not have disposed of Resident #4's medications in a trash roll out cart that went to the street because anyone could find and take the resident's medications.	C 365		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain an accurate record of controlled substances that documented the receipt, administration, and disposition of controlled substances for 2 of 2 sampled residents (#1 and #3) who had orders for controlled substances. The findings are: Review of the facility's controlled substance policy dated 08/17/17 revealed:	C 367		

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C 367	Continued From page 43 -The facility would document receipt of controlled substances, administration, and disposition of controlled substances. -Controlled substance records should be maintained with the resident's record and in such an order that there can be accurate reconciliation. -Controlled substances should be counted at the end of each day by the Administrator and one other designated staff member for reduced amounts and accountability. 1. Review of Resident #1's current FL-2 dated 11/20/23 revealed: -Diagnoses included bipolar disorder and vitamin D deficiency. -There was an order for lorazepam (an anti-anxiety medication) 1mg at night. 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, 2024. -Resident #1 was initially admitted to the transferring facility on 11/01/23. -The transferring facility and current facility were owned and operated by the same owner and Administrator. -Resident #1's facility healthcare records and medications were included in the transfer and were continued at the current facility. Review of Resident #1's signed medication orders upon admission to the facility, dated 11/01/23, revealed there was an order for lorazepam 1mg every night for anxiety/insomnia. Review of Resident #1's medication orders revealed: -There was an order for lorazepam 1mg at night dated 11/27/23.	C 367		

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C 367	Continued From page 44 -The order was electronically signed by Resident #1's mental health provider. Review of a hospital After Visit Summary dated 11/27/23 revealed: -Resident #1 was hospitalized 11/26/23 through 11/27/23 for the evaluation and treatment of seizures. -Resident #1 was to stop taking lorazepam 1mg. -Resident #1 was to start taking temazepam 30mg at night for sleep. Review of Resident #1's MARs dated 01/13/24 through 02/08/24 revealed: -There was not an entry for lorazepam. -There was not an entry for temazepam. Observations of Resident #1's medications on hand on 02/08/24 at 4:06pm revealed: -The facility had one bubble pack card for lorazepam 1mg every night for Resident #1. -The pharmacy label showed 30 tablets of lorazepam 1mg dispensed 11/27/23. -There were 13 tablets of lorazepam remaining in the bubble pack. -Temazepam was not on hand in Resident #1's mediations. -There was no record that documented the receipt, administration and disposition of controlled substances. Telephone interview with a pharmacist with the facility's contracted pharmacy on 02/09/24 at 8:43am revealed: -Resident #1 was admitted to their services on 11/02/23. -Resident #1 was ordered lorazepam 1mg each night for sleep/anxiety on 11/02/23. -Lorazepam was an anti-anxiety medication and was considered a controlled substance.	C 367		

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C 367	Continued From page 45 -The pharmacy was not able to fill or dispense Resident #1's lorazepam on 11/02/23 because the order did not include all required information. -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 facility for Resident #1. -On 11/27/23 at 2:44pm, the facility faxed the hospital After Visit Summary dated 11/27/23, that included orders for Resident #1 to stop taking lorazepam 1mg and start taking temazepam 30mg. -The pharmacy placed a stop on the lorazepam. -The pharmacy was not able to fill or dispense the temazepam because the order on the hospital After Visit Summary did not include all required information. -There was no current order for Resident #1 to receive lorazepam. -Resident #1 should have had 30 of 30 tablets of lorazepam 1mg in the pharmacy bubble pack that was dispensed on 11/27/23 because according to the hospital After Visit Summary the lorazepam was stopped 11/27/23 at 2:44pm. Interview with the Administrator on 02/09/24 at 11:53am revealed: -The facility did not have an accurate record that showed the receipt, administration and disposition of Resident #1's lorazepam. -She was aware of the requirements related to the documentation of controlled substance, but the medication aides had not followed the facility's policy. The staff member who documented on Resident #1's MAR was no longer employed at the facility as of 02/08/24.	C 367		

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C 367	Continued From page 46 2. Review of Resident #3's current FL-2 dated 03/03/23 revealed: -Diagnosis included schizophrenia. -There was an order for Klonopin 1mg, take 3 tablets (3mg) every evening (Klonopin is used to treat anxiety). Review of Resident #3's December 2023 medication administration record (MAR) revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 12/01/23 to 12/31/23. Review of Resident #3's January 2024 MAR revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 01/01/24 to 01/31/24. Review of Resident #3's February 2024 MAR revealed: -There was an entry for Klonopin 1mg, take 3 tablets (3mg) at 8:00pm every evening. -There was documentation Klonopin 1mg, 3 tablets (3mg) were administered at 8:00pm from 02/01/24 to 02/06/24. Request for Resident #3's December 2023 and February 2024 controlled substance record (CSR) on 02/08/24 at 11:10am and 5:00pm from the Administrator was unsuccessful. Review of Resident #3's January 2024 CSR revealed: -There was a CSR secured to the back of	C 367		

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C 367	Continued From page 47 Resident #3's Klonopin bubble card with a rubber band. -The CSR had a printed label from the facility's contracted pharmacy with Klonopin 1mg, take 3 tablets (3mg) every evening, a dispensing date of 01/05/24, and a quantity of 90 tablets. -The CSR had a space for staff to sign if they administered the medication, the date and time the medication was administered, the amount given and the amount of the Klonopin remaining. -The CSR was blank. Observation of medications on hand on 02/08/24 at 4:49pm revealed there were 21 Klonopin 1mg tablets, a 7 day supply available for administration. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/09/24 at 10:19am revealed: -90 Klonopin 1mg tablets were dispensed for Resident #3 on 12/09/23; a 30 day supply. -90 Klonopin 1mg tablets were dispensed for Resident #3 on 01/05/24, a 30 day supply. -The pharmacy sent a CSR secured to each controlled substance medication to the facility when a controlled substance was dispensed. Telephone interview with Resident #3's psychiatrist on 02/09/24 at 10:00am revealed: -Resident #3 had a history of hallucinations and delusions, and Klonopin helped decrease his hallucinations and delusions. -The facility should maintain a CSR with each staff counting off with each other and to ensure controlled substances were documented to ensure Resident #4 received his medications as ordered but also to ensure there was no drug diversion at the facility.	C 367		

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C 367	Continued From page 48 Telephone interview with Resident #3's primary care provider (PCP) on 02/09/24 at 12:47pm revealed: -Resident #3 was prescribed Klonopin to help control his anxiety, hallucinations, and delusions. -The facility should have CSR to ensure the facility had a system in place to ensure the facility followed the law, ensure there was no drug diversion, and to ensure the resident was administered medications as ordered. -She expected the facility to count controlled substances at the end of each shift. Interview with the Administrator on 02/09/24 at 11:48am revealed: -She administered Resident #3 Klonopin 1mg, 3 tablets (3mg) every evening before bedtime. -Resident #3 had never been out of his prescribed medications. -If Resident #3 did not receive his medications as ordered he acted very immature, played in the toilet, and put objects in his ears and nose. -The resident had not had any behavioral issues in the past six months and had received his Klonopin every night at bedtime. -She could not explain why Resident #3 had a 7 day supply of Klonopin on hand. Interview with the Administrator on 02/09/24 at 11:48am revealed: -She kept a CSR for Resident #3 but did not document on the CSR. -She thought that the CSR sent from the facility's contracted pharmacy secured to the back of the Klonopin bubble card was sufficient. -She later explained that another medication aide (MA) that worked at the facility made the mistake of not documenting on Resident #3's CSR. -The MA resigned on 02/08/24. -She was not sure why she or the MA had not	C 367		

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C 367	Continued From page 49 documented the administration of Resident #4's Klonopin on the CSR. Attempted interview with Resident #3 on 02/09/24 at 02/09/24 at 8:23am was unsuccessful.	C 367		
C 370	10A NCAC 13G .1008 (d) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to return a controlled substance medication to the facility's contracted pharmacy after the resident was discharged from the facility	C 370		

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C 370	Continued From page 50 and the resident's responsible party forgot to take the medications with her at the time of discharge (#4). The findings are: Review of the facility's controlled substance policy dated 08/17/17 revealed: -The facility should document receipt of controlled substances, administration, and disposition of controlled substances. -Controlled substance records should be maintained with the resident's record and in such an order that there can be accurate reconciliation. -Controlled substances that are expired, discontinued, or no longer required for a resident will be returned to the pharmacy within 90 days of expiration or discontinuation of the controlled substance or following the death of a resident. -The facility should document the resident's name, the name, strength, and dosage form of the controlled substance; and the amount returned. -If the pharmacy will not accept the return of a controlled substance, the Administrator or the Administrator's designee will destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the residents. -The destruction should be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. -The destruction should be conducted so that no person can use, administer, sell or give away the controlled substance. -Records of controlled substances destroyed should include the resident's name; the name, strength, and dosage form of the controlled substance; the amount destroyed; the method of	C 370		

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destruction; and the signature of the Administrator or the Administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee or the licensed pharmacist or dispensing practitioner.
-There should be documentation by the pharmacy of the receipt or return of the controlled substance.
-Records of the controlled substances returned to the pharmacy or destroyed by the facility will be maintained by the facility for a minimum of three years.

Review of Resident #4's current FL-2 dated 11/20/23 revealed:
-Diagnoses of pulmonary embolism, seizure, major depressive disorder, chronic obstructive pulmonary disease (COPD), and intellectual disability.
-There was an order for Phenobarbital 32.4mg, take one tablet daily at 8:00am and 8:00pm (Phenobarbital is a controlled substance used to treat seizures).

Interview with the Administrator on 02/08/24 at 11:30am revealed:
-Resident #4 was discharged on 12/09/23 when a family member came to pick him up from the facility.
-The family member forgot to take the resident's medications with her when she left the facility with Resident #4.
-She spoke with the family member by telephone approximately 15 minutes after the resident left with his family member and asked the family member to return to the facility to pick up the resident's medications.
-The family member did not return to pick up Resident #4's medications.
-She threw Resident #4's Phenobarbital away a

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C 370	Continued From page 52 few days after the resident's family did not return to get the resident's medications. -She placed the resident's Phenobarbital in a plastic bag, tied the bag, and placed the plastic bag in the roll out trash can that goes to the street to be picked up weekly. -She did not have a system in place to document the medications and quantity of medications she disposed of; she did not think to contact the facility's contracted pharmacy to ask about returning the medications to the pharmacy. Observations of medications on hand on 02/08/24 at 4:51pm revealed there were no medications for Resident #4 available for administration. Observation of the facility's front porch on 02/08/24 at 8:15am revealed there was a locked secured box for the pharmacy to deliver medications to the facility. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/08/24 at 2:56pm revealed: -The pharmacy had a contract with the facility which included a process for the facility to appropriately return medications to the pharmacy. -The facility should have contacted the pharmacy to inform that Resident #4 had medications that needed to be returned. -The pharmacy would create a label to set up the return process, and the driver for the pharmacy that would drop off medications would retrieve the resident's medications from a locked box on the facility's front porch. -The facility should not have disposed of Resident #4's medications in a trash roll out cart that went to the street because anyone could find and take the resident's medications.	C 370		

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Telephone interview with Resident #4's psychiatrist on 02/09/24 at 10:00am revealed:
-She expected the facility to have a controlled substance medication disposal policy in place to ensure Resident #4's phenobarbital was destroyed properly.
-The Administrator placed other individuals at risk when she disposed of Resident #4's Phenobarbital in the trash roll out cart to the street.
-If another individual took the resident's Phenobarbital they may become "high," if they drove a vehicle after taking the medication, they placed themselves and others at risk of death.
-If an individual took Resident #4's Phenobarbital from the trash roll out cart they were at risk of death due to adverse side effects.

Telephone interview with Resident #4's primary care provider (PCP) on 02/09/24 at 12:47pm revealed:
-The facility should have disposed of Resident #4's Phenobarbital per the facility's policy.
-The Administrator placed others at risk when she disposed of the resident's Phenobarbital in the trash roll out cart because anyone could have accessed the medication.
-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 Phenobarbital.
-She 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL074050	A. BUILDING: _____ B. WING _____	02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L AND C FAMILY CARE HOME LLC	6347 FAIRWAY DRIVE GRIFTON, 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 370	Continued From page 54 the trash roll out cart. -She did not think to contact the facility's contracted pharmacy to ask for guidance on how to dispose of the resident's medication.	C 370		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 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 determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication	C 375		

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C 375	Continued From page 55 review in the resident's record; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly pharmacy reviews were completed for 2 of 3 sampled residents (#2, #3). The findings are: 1. Review of Resident #2's current FL-2 dated 01/16/23 revealed: -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 night. -There was an order for Tylenol (a medication used to treat pain and/or fever) 325mg, 2 tablets every 4 hours as needed. Review of Resident #2's Resident Register revealed he was admitted to the facility 08/30/17. Review of Resident #2's facility record on 02/09/24 revealed:	C 375		

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C 375	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 on10/24/23. -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. _____ 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 reviews. -The RN left that position and the Administrator had not hired a replacement for the RN.	C 375		