STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL073005	A. BUILDING: _____ B. WING _____	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES FAMILY HOME #1	2437 EPHESUS CHURCH ROAD SEMORA, NC 27343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-Up survey on March 5, 2024-March 6, 2024.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors accessible to a resident, who was identified as a wanderer, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of Resident #3's current FL-2 dated 06/16/23 revealed:	C 069		

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C 069	Continued From page 1	C 069		

-Diagnoses included schizoaffective disorder and tardive dyskinesia.
-Resident #3 was intermittently disoriented.
-Resident #3 was documented as a wanderer.

Observations of the facility's exit doors at various times on 03/05/24 between 8:00am-5:45pm revealed:
-On 03/05/24 at 8:00am, a resident opened the front door of the facility to allow the surveyor to enter the facility; the staff member was next door at the Owner's private residence.
-Residents were seen entering and exiting the facility through the front exit door at various times throughout the day on 03/05/24 and no alarms sounded.
-Staff was observed entering and exiting the facility through the back exit door at various times on 03/05/24 and no alarm sounded.
-Resident #3 was observed entering and exiting the facility at various times throughout the day.

Interview with the Supervisor in Charge (SIC) on 03/05/24 at 1:49pm revealed:
-She had a key to turn the door alarms on and off.
-Both the front door and the back door were alarmed.
-Alarms were cut on in the evening and off in the mornings.

Second interview with the SIC on 03/05/24 at 4:59pm revealed:
-It was like a mother's instinct to keep an eye on Resident #3.
-She could do what needed to be done in the facility and was constantly checking on Resident #3.
-She knew Resident #3's routine, he walked in the front yard and back yard.
-Resident #3 "may just pace up and down the

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C 069	Continued From page 2 porch." Observation of the facility's back door on 03/05/24 at 2:50pm revealed there was no alarm on the door. Interview with the Owner/Director on 03/05/24 at 2:50pm revealed: -The door alarms were cut on at bedtime and cut off in the morning. -He took the door alarm to the back door next door to his private residence by mistake. -He had an alarm on Resident #3's bedroom door because the resident got up during the night. -The alarm on Resident #3's bedroom door went off in the staff room to let the staff know Resident #3 was up and moving. Observation of the door alarm on Resident #3's door on 03/05/24 at 3:00pm revealed the door alarm did not work. Interview with the Owner/Director on 03/05/24 at 2:50pm revealed: -The alarm was working two weeks ago when he checked it. -He checked the alarm once a month. -Someone was in the facility 24 hours a day. -Someone had to be awake 24 hours a day because of Resident #3. Telephone interview with the Owner/Director on 03/05/24 at 5:35pm revealed: -Resident #3 wore a bracelet to monitor the resident if the resident "walked off." -Resident #3 would walk off and he had walked off a couple of times. -Resident #3 was watched 24/7, someone was awake all the time to watch Resident #3. -When the door alarm was off during the day,	C 069		

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C 069	Continued From page 3	C 069		

Resident #3 was watched 24/7.
-During the day Resident #3 was watched constantly.
-When Resident #3 walked off last fall, "we had blinked" but it had not happened again.
-Resident #3 had received the bracelet after the last time he walked off.

Telephone interview with a representative at the local sheriff's office on 03/06/24 at 10:02am revealed:
-Resident #3 had a bracelet through the Project Lifesaver program because the Owner/Director had reported the resident was at risk of wandering off.
-The bracelet could be used to locate Resident #3 if he wandered away from the facility.

Project Lifesaver is a search and rescue program operated by public safety agencies and is strategically designed for at-risk individuals who are prone to the life-threatening behavior of wandering. The primary mission is to provide a timely response to save lives and reduce potential injury for adults and children with the prosperity of wandering due to a cognitive condition.

Telephone interview with Resident #3's primary care provider on 03/06/24 at 10:10am revealed:
-Resident #3 had wandered away from the facility before but the resident had a bracelet now.
-From what she was told Resident #3 had not been wandering lately.
-She thought the facility had alarms on the doors that could be turned on and off.
-It would be helpful to have the door alarm on but could see where it might be annoying with the residents going in and out.
-If other residents were outside, the residents would let staff know if Resident #3 walked off.

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C 069	Continued From page 4 Telephone interview with Resident #3's guardian on 03/06/24 at 11:49am revealed: -Resident #3 required constant supervision, 24/7. -Resident #3 had an extensive history of delusions and that put the resident at risk as well as others at risk and that was why the resident needed to be always monitored. -Resident #3 had been in and out of hospitals and other facilities because of his delusions and elopements. -He thought the facility had alarms on all the exit doors; he recalled hearing an alarm when visiting the facility. -It could be challenging for a staff person to do what they needed to do and watch Resident # so he thought the doors needed a chime of some sort to alert the staff when the resident exited the facility due to the level of supervision Resident #3 needed. Observation of Resident #3 on 03/06/24 at 12:03pm revealed: -Resident #3 was on the porch with another resident. -The other resident went back inside the facility and Resident #3 walked off the porch, down the driveway, up the state road to the Owner/Directors driveway, stood in the driveway for a couple of minutes, and retraced his steps back to the facility. -There were no staff or residents outside the facility. Observation of the facility on 03/06/24 at 12:49pm revealed: -The back door had an audible chime that could be heard when the door was opened. -No chime or alarm could be heard when the door was opened.	C 069		

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C 069	Continued From page 5 Interview with the SIC on 03/06/24 at 12:49pm revealed: -The front door was not going to alarm when opened because the front door alarm was only going to be turned on at night. -"We are not going to turn it on during the day because the residents were going in and out all day." -The front door alarm did not need to be on during the day because there were staff at the facility 24/7. Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed: -She knew Resident #3 was at risk of wandering. -There were alarms on the doors so staff would know when the residents went in and out of the facility. -She thought the door alarms were always on. -She expected the door alarms to be always turned on.	C 069		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the	C 131		

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C 131	Continued From page 6 facility failed to ensure that 1 of 3 staff sampled (Staff B) who administered medications had completed the state-approved 5-hour and 10-hour or 15-hour medication aide (MA) training courses as required. The findings are: Review of Staff B's, Supervisor in Charge (SIC), personnel record revealed: -There was a signed job description dated 01/03/21. -There was documentation of Staff B completing the medication administration clinical skills validation checklist on 01/21/21. -There was documentation of Staff B passing the MA written exam on 08/11/00. -There was no MA verification form for Staff B. -There was no documentation of Staff B completing the state-approved 5, 10, or 15-hour MA training courses. Review of resident medication administration records (MAR) for January 2024 and February 2024 revealed Staff B had administered medications to the residents on multiple occasions. Interview with Staff B on 03/06/24 at 12:30pm revealed: -He administered the residents' medications when he worked at the facility. -He went to several medication training classes led by a nurse prior to taking the state medication exam. -He did not recall if he had received a certificate when he took the classes. Telephone interview with the Administrator 03/06/24 at 1:08pm revealed:	C 131		

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C 131	Continued From page 7 -She thought Staff B had the required MA training to administer medications. -She did not know why Staff B's required MA training documents were not in his staff record. -She expected all staff to have a two-step TB test. Prior to the exit of the survey on 03/06/24, copies of Staff B's state-approved 5, 10, or 15-hour MA training certificate were not provided.	C 131		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) was tested upon hire for Tuberculosis (TB) disease in compliance with the TB control measures adopted by the Commission for Health Services. The findings are: Review of Staff B's, Supervisor in Charge (SIC),	C 140		

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C 140	Continued From page 8 personnel record revealed: -There was a signed job description dated 01/03/21. -There was a negative tuberculosis (TB) skin test that was read on 08/06/21. -There was no documentation that a second tuberculosis skin test was administered. Review of resident medication administration records (MAR) for January 2024 and February 2024 revealed Staff B had administered medications to the residents on multiple occasions. Interview with Staff B on 03/06/24 at 12:30pm revealed he had had two TB tests since he started working at the facility; he did not know why copies of both were not in his staff record. Telephone interview with the Administrator 03/06/24 at 1:08pm revealed: -She thought Staff B had a two-step TB test. -She did not know why Staff B's TB test results were not in his staff record. -She expected all staff to have a two-step TB test. Prior to the exit of the survey on 03/06/24, copies of Staff B's second TB skin test was not provided.	C 140		
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;	C 148		

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C 148	Continued From page 9 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff B) prior to hire. The findings are: Review of Staff B's, Supervisor in Charge (SIC), personnel record revealed: -There was a signed job description dated 01/03/21. -There was no documentation a drug screen had been completed. Interview with Staff B on 03/06/24 at 12:30pm revealed: -He had a drug screen completed a couple of years ago. -He thought the drug screen results were in his personnel record. Telephone interview with the Administrator 03/06/24 at 1:08pm revealed: -She thought Staff B had a drug screen. -She did not know why Staff B's drug screen results were not in his staff record. -She expected all staff to have a drug screen upon hire. Prior to the exit of the survey on 03/06/24, a copy of Staff B's drug screen was not provided.	C 148		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination	C 202		

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C 202	Continued From page 10 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) had completed two-step tuberculosis (TB) testing in compliance with the control measures of the Commission for Health Services. The findings are: Review of Resident #1's current FL-2 dated 08/16/23 revealed diagnoses included hepatic encephalopathy, severe alcohol use, and dementia. Review of Resident #1's Resident Register revealed an admission date of 10/16/19. Review of Resident #1's tuberculosis (TB) skin test revealed: -A TB skin test was completed on 09/15/19 and the results were negative. -A TB skin test was completed on 11/20/19 and the results were negative. -A TB skin test was completed on 04/17/21 and the results were positive with an induration of 10 mm.	C 202		

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C 202	Continued From page 11 Telephone interview with a medical assistant at the clinic on 03/05/24 at 11:29am revealed: -The Owner/Director of the facility was notified Resident #4 had a positive TB skin test dated 04/17/21. -The Owner/Director was encouraged to get in touch with Resident #4's primary care provider (PCP) to do further testing through lab work or X-rays. Interview with Resident #1 on 03/05/24 at 4:33pm revealed he thought he remembered having a positive TB skin test, but he did not remember anything about it. Interview with the Owner/Director on 03/05/24 at 2:50pm revealed he did not remember Resident #1 having a positive TB skin test but "that was so far back it was hard to remember." Telephone interview with Resident #1's PCP on 03/06/24 at 10:10am revealed: -She was not aware Resident #1 had a positive TB skin test. -If she had been notified, she would have recommended Resident #1 have a chest X-ray to rule out TB. -She had not noted any concerning symptoms, but she would have a chest X-ray done "to be safe." Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed: -All residents were required to have a TB skin test completed before admission. -If a potential resident had a positive TB skin test, she would not admit the resident to the facility until the resident had been cleared of TB. -If a resident residing in the facility had a positive	C 202		

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C 202	Continued From page 12 TB skin test, she would talk to the PCP to discuss a treatment plan. -She was not aware Resident #1 had a positive TB skin test.	C 202		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 3 sampled residents related to blood pressure checks for a resident who had a new diagnosis of tachycardia (#4). The findings are: Review of Resident #4's current FL-2 dated 06/16/23 revealed diagnoses included schizophrenia, asthma, and chronic kidney disease. Review of Resident #4's primary care provider (PCP) visit summary dated 03/01/24 revealed: -Resident #4 was diagnosed with tachycardia (a heart rate of more than 100 beats per minute). -Resident #4's blood pressure (BP)was documented as 128/88 and his heart rate was	C 249		

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C 249	Continued From page 13 103. -There was an order for Metoprolol 25mg twice daily. -There was an order for BP checks twice daily. Review of Resident #4's April 2024 medication administration record (MAR) from 03/01/24-03/05/24 revealed: -There was no entry to check blood pressure twice daily. -There was no documentation of Resident #4's BP. Interview with Resident #4 on 03/05/24 at 1:42pm revealed staff had not checked his BP. Interview with the Supervisor in Charge (SIC) on 03/05/24 at 1:49pm revealed: -She did not check Resident #4's BP. -She did not know there was an order to check Resident #4's BP twice daily. -If she had known there was an order, she would have checked Resident #4's BP. Interview with another Owner/Director on 03/05/24 at 2:50pm revealed: -He was working when Resident #4 was seen by the PCP. -The PCP may have told him Resident #4 had new orders, but he did not remember. -He "evidently was not paying attention", or he would have started checking Resident #4's BP that day. Observation of Resident #4's BP on 03/05/24 at 4:46pm revealed a BP reading of 122/88 and a pulse of 120. Telephone interview with Resident #4's primary care provider (PCP) on 03/06/24 at 10:10am	C 249		

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JONES FAMILY HOME #1	2437 EPHESUS CHURCH ROAD SEMORA, NC 27343

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C 249	Continued From page 14 revealed: -Resident #4 had tachycardia on 03/01/24 and she ordered twice daily BP checks to monitor the resident's BP and heart rate. -She expected the facility staff to implement the order. Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed: -Any new orders should go into effect immediately. -If Resident #4 had an order for BP checks, she expected the resident's BP to be checked the same day.	C 249		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to offer snacks to the residents three times a day. Interview with a resident on 03/05/24 at 9:44am revealed he was given a snack once a day; he would like snacks more often.	C 272		

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C 272	Continued From page 15 Interview with a second resident on 03/05/24 at 10:00am revealed: -The residents were not given snacks. -The only snacks he ate were snacks he had to buy himself. Interview with a third resident on 03/05/24 at 10:40am revealed the only time he had a snack was at night and he had to buy the snack himself. Interview with a fourth resident on 03/05/24 at 10:50am revealed: -He got meals every day at the facility. -He did not get food except for meals. Interview with a fifth resident on 03/05/24 at 4:33pm revealed: -He did not get snacks to eat at the facility. -Sometimes he got hungry and would like to have snacks available. Interview with a sixth resident on 03/05/24 at 4:36pm revealed they only received snacks if there were any. Interview with the Supervisor in Charge (SIC) on 03/05/24 at 4:59pm revealed: -She gave the residents snacks at any given time. -Sometimes the residents did not even want a snack. -She had not offered the residents a snack today, 03/05/24 at 10:00am and 2:00pm because she was "just busy." -The snacks provided were apple sauce and "sodas." -"These residents get snacks, more than enough." Interview with the Owner/Director on 03/05/24 at	C 272		

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C 272	Continued From page 16 2:50pm revealed: -The residents were given snacks every day, things like drinks, cookies, and cakes that he provided. -There were always snacks available during the day if the residents wanted them. -There was not a certain time snacks were offered but there were usually cakes and bananas sitting around. -Today, 03/05/24, the residents received their snack at lunchtime. -The residents liked to have a drink with their lunch instead of earlier; a drink was considered a snack. Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed she expected snacks to be provided three times per day, every day at 10:00am, 2:00pm, and 6:00pm.	C 272		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to ensure activities were provided to promote the residents' involvement and engage the residents who resided in the facility. The findings are: Observation of the residents on 03/05/24 at various times from 8:00am-5:00pm revealed:	C 288		

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C 288	Continued From page 17 -Two residents were at a day program until approximately 4:00pm. -Four residents sat in their rooms, in the living room, or outside on the porch. -There were no activities offered to the residents. Observation of the facility on 03/05/24 revealed there was no March 2024 calendar posted. Review of the February 2024 activity calendar revealed: -There were morning exercises every day from 9:00am-10:00am. -There was either a coffee and chat or a walking club daily from 12:00pm-2:00pm. -There was an activity listed at 6:00pm. Observation of the facility on 03/05/24 at various times between 8:00am-5:45pm revealed no activities were observed being offered to the residents. Interview with a resident on 03/05/24 at 9:44am revealed: -The facility did not provide activities. -He mostly rested during the day. -He would like to have something to do that would help with the coordination of his eyes, like a word search. Interview with a second resident on 03/05/24 at 10:00am revealed: -The only activity they had to do was watch television. -He would like to play cards if someone would play with him. Interview with a third resident on 03/05/24 at 10:40am revealed: -There was nothing to do at the facility.	C 288		

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C 288	Continued From page 18 -He would like to play cards or basketball. Interview with a fourth resident on 03/05/24 at 10:50am revealed: -He helped do chores around the facility. -He spent the rest of the day watching television or smoking. -He could not think of anything he would like to do. Interview with a fifth resident on 03/05/24 at 4:33pm revealed: -There were no activities to do at the facility. -He wished he had more to do. Interview with a sixth resident on 03/05/24 at 4:36pm revealed the facility did not offer activities but he stayed busy with his electronic devices. Interview with the Supervisor in Charge (SIC) on 03/05/24 at 4:59pm revealed: -She did not do activities with the residents. -The residents slept, watched television, smoked cigarettes, and "that was it." -The residents who were eligible to go to a day program were asked if they wanted to go to a day program and they did not want to. Observation of a locked closet on 03/05/24 at 3:37pm revealed: -At the bottom of the food pantry closet, several boxes contained board games. -The board games were stacked beneath other items. -The boxes of the board games were covered in a thin layer of dust. Interview with the Owner/Director on 03/05/24 at 2:50pm revealed: -A named SIC was the Activity Director and was	C 288		

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C 288	Continued From page 19 responsible for keeping the monthly activity calendar updated. -There were games at the facility but they were kept locked up so they could make sure the games were taken care of. -The residents could have the games at any time, they just had to ask. Interview with the named SIC on 03/06/24 at 12:30pm revealed: -He was responsible for completing the activities calendar every month. -He had been busy helping with transportation to appointments and had not had a chance to do the activities calendar for March 2024. -He started the activities calendar for March 2024, today, 03/06/24. -He did activities with the residents when he worked. -Whatever staff was working should be doing activities with the residents. Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed: -She expected an activities calendar to be updated each month. -Staff should go to each resident and find out what the residents wanted to do. -Staff could not make the residents participate but activities should be offered.	C 288		
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:	C 330		

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C 330	Continued From page 20 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 sampled residents (#3, #4) related to medication used to treat involuntary movements (#3) and a blood pressure medication (#4). The findings are: 1. Review of Resident #3's current FL-2 dated 06/16/23 revealed diagnoses included schizoaffective disorder and tardive dyskinesia. Observation of Resident #3 on 03/05/24 at various times between 8:00am-5:45pm revealed: -Resident #3 was observed with tremors from his elbows to his hands when he was ambulating in the facility. -Resident #3's hands were observed to be shaking when he was sitting. -Resident #3's arms were observed to be shaking from the elbow down when the resident was standing. -When Resident #3 saw someone looking at him, he would place his hands in his pockets. -Resident #3 had tremors that caused his beverage to spill over when he was setting his glass on the table. Review of Resident #3's physician's order dated 12/27/23 revealed an order for Benztropine 1mg taken twice daily for tremors.	C 330		

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C 330	Continued From page 21 Review of Resident #3's February 2024 medication administration record (MAR) revealed: -There was an entry for Benztropine 1mg with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Benztropine 1mg was administered twice daily from 02/01/24-02/29/24. Review of Resident #3's April 2024 MAR from 04/01/24-04/05/24 revealed: -There was an entry for Benztropine 1mg with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that Benztropine 1mg was administered twice daily from 03/01/24-03/04/24 and at 8:00am on 03/05/24. Observations of Resident #3's medications on hand on 03/05/24 at 2:26pm revealed: -There was a 30-day box of Resident #3's medications. -The box was labeled with the resident's name and medication contained within the box. -Resident #3's Benztropine 1mg was listed on the top of the medication box. -Inside the box were individual packets of medication, each packet was labeled with the name of the medication and the time the medication was to be administered, before breakfast, morning, and bedtime. -Resident #3's Benztropine was not listed on any of the individual packets contained within the box. Second observations of Resident #3's medications on hand on 03/05/24 at 4:00pm revealed: -There was a 30-day box of Resident #3's medications delivered to the facility on 03/05/24 for the next cycle of medication.	C 330		

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C 330	Continued From page 22 -Resident #3's Benztropine was listed on the individual packets contained within the box for a morning dose and a bedtime dose. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/05/24 at 4:07pm revealed: -Benztropine was used to treat tardive dyskinesia and involuntary movements. -If Resident #3's Benztropine was not being administered as ordered, the resident's tremors would not improve and could get worse. -Their computer system showed Resident #3's Benztropine was dispensed on 02/05/24 for a 30-day supply. -Sometimes the machine may not "drop" the medication. -If the medication was not in the individual packets delivered to the facility, the facility staff should have given the pharmacy a call and the medication would have been delivered immediately. Interview with the Supervisor in Charge (SIC) on 03/05/24 at 1:49pm revealed: -When she administered medication she compared the individual packets to the residents' MAR, and if the medication matched, she opened the packet, and administered the medication; she would then document on the MAR. -She had documented administering Resident #3's Benztropine because she thought the medication was in the individual packets of medication. -She had not noticed Resident #3's Benztropine was not in the packets of medication labeled for Resident #3. Interview with Resident #3 on 03/05/24 at 4:42pm revealed:	C 330		

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C 330	Continued From page 23 -He thought his shaking was "bad." -His neurological medications caused him to shake. -He thought his shaking was getting worse. Interview with the Owner/Director on 03/05/24 at 2:50pm revealed: -When the SIC was administering medication, he expected the SIC to look at the individual medication packets, match the packets to the MAR, and administer the medication. -He was not aware Resident #3's Benztropine was not in the resident's individual medication packets. -If the medication was not in the resident's packet, he expected the SIC to document the medication was not available on the MAR and to contact the pharmacy to obtain the medication. Telephone interview with Resident #3's PCP on 03/06/24 at 10:18am revealed: -Resident #3 missing his dose of Benztropine for one month could cause the resident's tremors to worsen. -Resident #3's tremors could affect his ability to perform his activities of daily living. Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed: -She expected the SIC to ensure all the medication was available to be administered, the medication was the correct dosage, and then administer the medication. -If a medication was not available she expected the SIC to call the pharmacy. Attempted telephone interview with Resident #3's mental health provider on 03/05/24 at 4:23pm was unsuccessful.	C 330		

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C 330	Continued From page 24 2. Review of Resident #4's current FL-2 dated 06/16/23 revealed diagnoses included schizophrenia, asthma, and chronic kidney disease. Review of Resident #4's primary care provider (PCP) visit summary dated 03/01/24 revealed: -Resident #4 was diagnosed with tachycardia (a heart rate of more than 100 beats per minute). -Resident #4's blood pressure (BP) was documented as 128/88 and his heart rate was 103. -There was an order for Metoprolol 25mg twice daily. Review of Resident #4's April 2024 medication administration record (MAR) from 03/01/24-03/05/24 revealed: -There was no entry for Metoprolol 25mg twice daily. -There was no documentation Metoprolol 25mg had been administered. Observations of Resident #4's medications on hand on 03/05/24 at 1:40pm revealed there was no Metoprolol available to be administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 03/05/24 at 12:51pm revealed: -A prescription for Resident #4's Metoprolol had not been received. -Metoprolol was usually used for BP or heart rate (tachycardia). -Resident #4's primary care provider (PCP) usually sent prescriptions to the pharmacy electronically. -She would have expected the staff at the facility to call to check on the medication when the medication had not been delivered.	C 330		

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C 330	Continued From page 25 -Resident #4 could experience the same symptoms he was having if the medication was not administered as ordered. Interview with Resident #4 on 03/05/24 at 1:42pm revealed he did not know if he had started any new medications; he took what the staff gave him. Interview with the Supervisor in Charge (SIC) on 03/05/24 at 1:49pm revealed: -She did not know there was an order for Metoprolol for Resident #4. -The pharmacy had not dispensed Metoprolol for Resident #4. Interview with the Owner/Director on 03/05/24 at 2:50pm revealed: -He was working when Resident #4 was seen by the PCP. -The PCP may have told him Resident #4 had new orders, but he did not remember. -If he had known the PCP was starting a new medication, he would have told her to send a prescription for Resident #4's Metoprolol to the pharmacy. Observation of Resident #4's BP on 03/05/24 at 4:46pm revealed a BP reading of 122/88 and a pulse of 120. Telephone interview with Resident #4's PCP on 03/06/24 at 10:10am revealed: -Resident #4 had tachycardia on 03/01/24 and she ordered Metoprolol to help slow the resident's heart rate. -Long term, an elevated heart rate could cause an enlarged heart and congestive heart failure. -It was concerning Resident #4's heart rate was still elevated.	C 330		

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C 330	Continued From page 26 -She would have expected the medication to have been administered as ordered. Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed: -Any new orders should go into effect immediately. -If Resident #4's Metoprolol had not been delivered from the pharmacy, she expected the SIC to let the pharmacy know the medication had not been received.	C 330		
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, record reviews, and interviews, the facility failed to ensure there were readily retrievable records for controlled substances by documenting the receipt, administration, and disposition of 2 of 2 sampled residents with an order for a medication used to treat anxiety (#3, #5). The findings are: 1. Review of Resident #3's current FL-2 dated 11/29/22 revealed: -Diagnosis included undifferentiated schizophrenia. -There was an order for Lorazepam 1mg (used to	C 367		

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C 367	Continued From page 27 treat anxiety) every 8 hours as needed (PRN). Review of Resident #3's medication administration record (MAR) revealed: -On the front of the January 2023 MAR, Lorazepam was documented as administered 24 times; 19 times were documented on the back of the MAR. -On the front of the February 2023 MAR, Lorazepam was documented as administered 25 times; 19 times were documented on the back of the MAR. -On the front of the March 2023 MAR, Lorazepam was documented as administered 19 times; 19 times were documented on the back of the MAR. -On the front of the April 2023 MAR, Lorazepam was documented as administered 10 times; 3 times were documented on the back of the MAR. -On the May 2023 MAR, Lorazepam was not documented as administered. -On the front of the June 2023 MAR, Lorazepam was documented as administered 9 times; 7 times were documented on the back of the MAR. -On the front of the July 2023 MAR, Lorazepam was documented as administered 11 times; 11 times were documented on the back of the MAR. -On the front of the August 2023 MAR, Lorazepam was documented as administered 11 times; 11 times were documented on the back of the MAR. -On the front of the September 2023 MAR, Lorazepam was documented as administered 18 times; 18 times were documented on the back of the MAR. -On the October 2023-December 2023 MAR, Lorazepam was not documented as administered. -On the January 2024-March 2024 from 03/01/24-03/06/24 MAR, Lorazepam was not documented as administered.	C 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL073005	A. BUILDING: _____ B. WING _____	03/06/2024

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C 367	Continued From page 28 Review of Resident #3's controlled substance count sheet (CSCS) on 03/06/24 at 9:06am revealed: -There were three CSCS with a pharmacy label that read Lorazepam 1mg every 6 hours as needed for anxiety on each CSCS. -The pharmacy label read there were 60 Lorazepam 1mg tablets dispensed on each CSCS label. -There was no documentation on any of the CSCS, that Lorazepam 1mg had been administered to Resident #3. Observation of medication on hand for Resident #3 on 03/06/24 at 9:24am revealed: -There was a bubble pack with a pharmacy label that read Lorazepam 1mg every 6 hours as needed for anxiety. -The bubble pack was labeled 2 of 2 bubble packs dispensed on 01/31/23. -There were 60 Lorazepam tablets dispensed on 01/31/23: 30 tablets in each bubble pack. -There were 5 of 30 tablets remaining in the bubble pack. -There were no other packages of Lorazepam 1mg available. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/06/24 at 11:28am revealed: -The pharmacy had an order for Resident #3 for Lorazepam 1mg every 8 hours as needed. -The pharmacy dispensed 60 Lorazepam 1mg tablets on 01/03/23, 60 tablets on 01/31/23, and 60 tablets on 02/28/23; 180 tablets of Lorazepam 1mg had been dispensed for Resident #3 since 01/03/23. Interview with the Owner/Director on 03/06/24 at	C 367		

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C 367	Continued From page 29 1:30pm revealed if Resident #3's CSCS did not have any writing on them, he "evidently" missed it. Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/06/24 at 11:28am. Refer to the telephone interview with the Administrator on 03/06/24 at 1:08pm. 2. Review of Resident #5's current FL-2 dated 08/16/23 revealed: -Diagnosis included schizophrenia. -There was an order for Lorazepam 0.5mg (used to treat anxiety) twice daily, in the afternoon and at bedtime. Review of Resident #5's February 2024 medication administration record (MAR) revealed: -There was an entry for Lorazepam 0.5mg twice daily with a scheduled administration time of 3:00pm and 8:00pm. -There was documentation Resident #5 Lorazepam was administered at 3:00pm and 8:00pm from 02/01/24-02/29/24. Review of Resident #5's controlled substance count sheet (CSCS) on 03/05/24 at 11:15am revealed: -There were 2 CSCS with a pharmacy label that read Lorazepam 0.5mg take one tablet twice daily on each CSCS. -The pharmacy label read there were a total of 60 Lorazepam 0.5mg tablets dispensed on 02/05/24. -The top of one of the CSCS for Lorazepam 0.5mg had 8:00am written in; the other CSCS had 8:00pm written in. -There was documentation on both CSCS that Lorazepam 0.5mg had been administered to	C 367		

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C 367	Continued From page 30 Resident #5 twenty-five times on each CSCS for a total of 50 Lorazepam. -There was no date or time completed to know when the medication had been administered. Observation of medication on hand for Resident #5 on 03/05/24 at 11:17am revealed: -There was a box of medication labeled for Resident #5. -Inside the box were disposable pouches labeled with the resident's daily medications. -Resident #4's Lorazepam was included with the other daily medications. -There were six days of medication remaining (a total of 12 Lorazepam 0.5mg). Interview with the Supervisor-in-Charge (SIC) on 03/06/24 at 8:36am revealed: -She administered Resident #5's Lorazepam at 8:00am and 8:00pm. -She was supposed to sign her name, date, and time the medication was administered. -She "clearly just overlooked it." Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/06/24 at 11:28am. Refer to the telephone interview with the Administrator on 03/06/24 at 1:08pm. _____ Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/06/24 at 11:28am revealed: -The pharmacy sent a CSCS with each bubble pack. -The CSCS was to be used by the medication aide to an accurate count of the controlled substance.	C 367		

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C 367	Continued From page 31 Telephone interview with the Administrator on 03/06/24 at 1:08pm revealed: -When a controlled substance was administered the SIC should document on the MAR and the CSCS. -Documentation on the CSCS included the date, time, dose, and the person who administered the medication. -She expected the SIC to document on the MAR and CSCS each time a controlled substance was administered.	C 367		