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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from October 16, 2024 to October 17, 2024.	C 000		
C 102	10A NCAC 13G .0317 (a) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure fire safety equipment was maintained in a safe operating condition for four smoke detectors that did not have an operable battery. The findings are: Review of the Inspection of Residential Care Facility dated 09/03/24 revealed: -An inspection was completed on 09/03/24. -The facility code status was an A with 6 demerits. -There was no documentation relating to smoke detectors. Observation of the facility on 10/16/24 from 7:55am to 10:15am revealed: -There was a loud beeping sound coming from	C 102		

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several smoke detectors in the facility.
-There were three smoke detectors beeping in three resident's rooms where three residents resided.
-There was one smoke detector beeping in a resident's room that was empty.

Interview with a resident on 10/16/24 at 8:26am revealed:
-The smoke detector in her bedroom had beeped for many weeks.
-Sometimes she had difficulty sleeping due to the chirping sounds from the smoke detector.
-She had complained to the Supervisor in Charge (SIC) about the beeping from the smoke detector.
-She heard other smoke detectors beeping when she was in the family room and kitchen.

Interview with a second resident on 10/16/24 at 8:57am revealed:
-The smoke detector in his room had been beeping for several weeks.
-The loud beeping from the smoke detector made it hard for him to sleep at times.
-The resident also heard several other smoke detectors that beeped in the home but was unsure where they were located.
-He could not remember if he had told staff at the facility about the smoke detectors in the facility beeping.

Interview with the SIC on 10/16/24 at 8:37am revealed:
-She had not noticed any smoke detectors beeping in the facility.
-She was not sure why the smoke detectors were beeping in the facility.
-The smoke detectors were in the facility to protect residents in case there was a fire.
-She was not aware that the smoke detector was

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beeping in each resident's room.
-She planned to notify the Administrator when he came to the facility on 10/16/24 about the smoke detectors beeping.

Observation of the facility on 10/16/24 at 9:14am revealed the Administrator arrived at the facility.

Second interview with the SIC on 10/16/24 at 9:55am revealed:
-The beeping of the smoke detectors in the facility "all just started."
-She first noticed the beeping sound from a smoke detector in the morning on 10/13/24.
-She noticed more smoke detectors beeping the evening of 10/13/24.
-She had not notified the Administrator that the smoke detectors started beeping because at first it was just one.
-She thought "since we had batteries, I figured I would let him (Administrator) know on Monday" 10/14/24.
-The Administrator did not come to the facility on 10/14/24 and she "knew she would tell him (Administrator) today" (10/16/24).

Interview with the Administrator on 10/16/24 at 10:00am revealed:
-He did not know that there were smoke detectors beeping in the facility because he had not heard the beeping.
-The SIC had not notified him of smoke detectors beeping in the home.
-The smoke detectors were beeping because they needed new batteries.
-Replacing the batteries was a "very quick fix."
-He would replace the batteries in the smoke detectors that were beeping in the facility today.

Interview with the Administrator on 10/17/24 at

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C 102	Continued From page 3 5:10pm revealed: -He was not aware that four smoke detectors needed batteries until yesterday. -The SIC should have notified him that smoke detectors were beeping in the facility so he could replace the batteries. -It was important to keep smoke detectors working properly to ensure the resident's safety. _____ The facility failed to ensure fire safety equipment was maintained in safe operating condition as evidenced by 4 beeping smoke detectors in resident bedrooms that were beeping due to inoperable batteries. The facility's failure to ensure the safe operating condition of fire safety equipment was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on November 5, 2024 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 1, 2024.	C 102		
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	C 131		

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C 131	Continued From page 4 medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 2 medication aides (Staff A) completed the clinical skills validation prior to the administration of medications to residents. The findings are: Review of the facility's handbook of services offered revealed medication administration by competent, trained, and designated staff. Review of Staff A's personnel record revealed: -Staff A was hired on 09/01/24 as a Supervisor in Charge (SIC) and Medication Aide (MA). -There was no documentation Staff A completed the clinical skills validation. -There was no documentation Staff A had taken and passed the medication aide exam. -Staff A completed the 15-hour medication aide training on 08/14/24. Review of a resident's September 2024 medication administration record (MAR) revealed Staff A documented administration of medications beginning 09/01/24. Review of a resident's October 2024 MAR revealed Staff A documented administration of medications 10/01/24 to 10/08/24. Interview with a resident on 10/16/24 at 9:05am revealed: -Staff A administered her medications in the morning and in the evenings. -The Administrator occasionally administered her	C 131		

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C 131	Continued From page 5 medications; however, Staff A administered her medications more often. Interview with a second resident on 10/16/24 at 8:00am revealed Staff A usually administered her medications. Interview with Staff A on 10/17/24 at 3:40pm revealed: -She began working at the facility on 09/01/24 as the SIC/MA -She was responsible for the administration of medications to residents. -She could not remember if she had completed the clinical skills validation prior to administering medications. Interview with the Administrator on 10/17/24 at 4:39pm revealed: -Staff A was hired 09/01/24 as the SIC/MA. -Staff A administered medications to residents when he was not at the facility. -He thought Staff A had completed the clinical skills validation prior to the administration of medications to residents. -It was his responsibility to ensure MAs had completed the clinical skills validation prior to administering medications.	C 131		
C 141	10A NCAC 13G .0406 (a)(1) Other Staff Qualification 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (1) have a job description that reflects actual duties and responsibilities and is signed by the administrator and the employee;	C 141		

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This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure a job description that reflected actual duties and responsibilities was signed by the Administrator and the employee for 1 of 2 sampled staff (Staff A).

The findings are:

Review of Staff A's personal record revealed:
-There was an offer of employment letter dated 09/01/24.
-Staff A was hired on 09/01/24.
-The offer of employment designated Staff A as "live in employment position," who reported to the Administrator.
-There was no job description for Supervisor in Charge (SIC).
-Staff A completed the 15-hour medication aide training on 08/14/24.

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C 141	Continued From page 7 Observation of the facility on 10/16/24 from 7:45am to 9:10am revealed: -The SIC was the only staff at the facility until 9:10am. -The Administrator arrived at the facility at 9:10am. Observation of the facility on 10/17/24 from 8:15am to 9:31am revealed: -The SIC was the only staff at the facility until 9:31am. -The Administrator arrived at the facility at 9:31am. Interview with Staff A on 10/17/24 at 3:40pm revealed: -She began working at the facility on 09/01/24 as the SIC/MA. -She was the only staff who was at the facility every day and evening. -She was responsible for the administration of medications to residents, preparing meals, and being available for the residents if they needed assistance. . Interview with the Administrator on 10/17/24 at 4:39pm revealed: -Staff A was hired 09/01/24 as the SIC/MA. -Staff A administered medications to residents when he was not at the facility. -Staff A was responsible for the overall operations of the facility when he was not at the facility.	C 141		
C 211	10A NCAC 13G .0702 (j) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination And Immunizations	C 211		

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C 211	Continued From page 8 (j) The facility shall make arrangements for a resident to be evaluated by a licensed mental health professional, licensed physician or licensed physician extender for follow-up psychiatric care within 30 days of admission or re-admission to the facility when the resident: (1) has been an inpatient of a psychiatric facility within 12 months prior to admission to the facility and does not have a current plan for follow-up psychiatric care; or (2) has been hospitalized due to threatening or violent behavior, suicidal ideation or self-harm, or other psychiatric symptoms that required hospitalization within 12 months prior to admission to the facility and does not have a current plan for follow- up psychiatric care. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that a resident was examined by a local physician or psychiatrist within 30 after admission and a plan for psychiatric follow up care for 1 of 3 sampled residents (#1) who was a patient at an inpatient psychiatric facility for 29 days for an involuntary commitment (IVC) prior to admission to the facility, with second IVC 14 days after she was admitted to the facility and went to a local emergency room (ER) for cutting her wrist with a disposable razor.	C 211		

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C 211	Continued From page 9 The findings are: Review of Resident #1's current FL-2 dated 08/22/24 revealed: -There was a diagnosis of schizoaffective disorder, bipolar type. -The resident's recommended level of care was family care home. Review of Resident #1's Resident Register revealed the resident was admitted on 09/09/24. Review of Resident #1's discharge summary dated 08/11/24 revealed: -Resident #1 was admitted to an inpatient psychiatric hospital on 08/11/24 with diagnoses of major depression with psychotic features and a suicidal attempt. -The resident was admitted for suicidal and homicidal ideation with auditory hallucinations. -The resident had additional diagnoses listed as suicidal behavior with attempted self-injury, generalized anxiety disorder with panic attacks, history of schizophrenia, history of posttraumatic stress disorder (PTSD), self-cutting of wrist, borderline personality disorder, hallucinations and impulse control disorder in adult. Review of Resident #1's Counseling Service Treatment (CST) plan dated 09/09/24 revealed: -It was completed by the Administrator. -The resident had a diagnosis of schizoaffective disorder. -The resident could be harmful to himself, and the resident had a history of suicidal attempts. -The resident needed medication and required redirection to help reduce suicidal attempts. -There was a goal for the resident to learn to adjust his mindset about suicidal ideation all the time as he struggled to stay focused, the resident	C 211		

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would exercise self-control.
-Services and interventions included a therapist who would use instructions, model and role play to build a general developmentally appropriate social skills and communication skills.
-The resident, facility staff and therapist would implement services and interventions for the resident to meet his goal.
-There was no documentation in the resident's record that the resident was seen by a therapist from 09/09/24 to 09/23/24.

Review of Resident #1's hospital discharge summary dated 09/30/24 revealed:
-Resident #1 was admitted to an inpatient psychiatric hospital on 09/23/24 with diagnoses of schizoaffective disorder, post-traumatic stress disorder (PTSD), insomnia and a suicidal attempt.
-Resident #1 was admitted as an involuntary commitment for suicidal ideation with an attempt to kill himself by cutting his arm.
-The resident had auditory hallucinations that were commanding in nature and visual hallucinations.
-The resident was admitted on 09/23/24 to the hospital and discharged to the facility on 09/30/24.
-Resident #1 presented to the inpatient psychiatrist hospital with racing thoughts and pressured speech.
-The resident had a history of psychosis.
-There was documentation that the resident needed to be seen by his primary care physician (PCP), there was not a time frame listed of how soon the resident needed to be seen by his PCP.
-There was a note that the facility would follow up with a PCP to schedule the appointment.
-There was documentation of discharge safety forms for the resident.

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C 211	Continued From page 11 -The resident identified people yelling and judging as specific events or changes that could quickly overwhelm him. -The resident listed a plan to walk or read to help if people yelled or judged him. -The resident listed coping skills as reading or coloring. -The resident listed that his plan to keep himself safe was to talk to someone. Review of Resident #1's current care plan dated 10/02/24 revealed: -The resident wandered and was injurious to others. -The resident was currently receiving medications for mental health illness and/or behaviors. -The resident had a history of developmental disabilities (DD) and mental illness. -The resident currently received mental health services. -There was a box checked at yes on the current care plan that the facility had made a referral for mental health services. -The resident was oriented, but his memory was forgetful, and he needed reminders. -The resident was independent with eating, toileting, walking, bathing, dressing, grooming, personal hygiene, and transferring. Review of Resident #1's record revealed: -There was a referral form for a local mental health provider that was signed by the resident on 09/17/24. -There was a referral form from a local primary care physician (PCP) and psychiatrist that was signed by the resident on 09/17/24. Telephone interview with certified medical assistant (CMA) from a psychiatrist office on 10/17/24 at 11:40am revealed:	C 211		

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-A representative from an inpatient psychiatric hospital scheduled an appointment for a psychological assessment for Resident #1 on 09/23/24.
-The appointment for Resident #1 on 09/23/24 was cancelled and rescheduled for 09/24/24 because the resident was still in the hospital.
-Resident #1's appointment for 09/24/24 was cancelled by a representative from an inpatient psychiatric hospital because the resident had not been discharged.
-There was no record of any appointments scheduled for Resident #1 since 09/24/24.

Interview with Resident #1 on 10/16/24 at 8:57am revealed:
-He enjoyed reading, cooking and listening to music.
-He had suicidal ideations, was diagnosed post-traumatic stress disorder (PTSD), paranoid schizophrenia, bipolar disorder, major depression, and was developmentally delayed.
-He had not been seen by a psychiatrist or PCP since he was admitted to the facility.

Observation of Resident #1 on 10/16/24 at 10:28am revealed:
-He was making coffee at the kitchen counter and cursing at another resident who was sitting at the kitchen table.
-Resident #1 was angry with the other resident for talking and told the other resident that he was the police and could have the other resident arrested for talking about other races.
-Resident #1 returned to the couch and listened to his music with headphones.

Second observation of Resident #1 on 10/16/24 at 11:51am revealed:
-The Supervisor in Charge (SIC) was in her

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bedroom at the end of a hallway with her bedroom door shut.
-Resident #1 was in his bedroom with the door closed at the other end of the hallway from the SIC bedroom.
-The surveyor heard Resident #1 yell from his bedroom for help four times yelling, "I need some help in here."
-After the SIC did not respond to Resident #1, the surveyor knocked on Resident #1's bedroom door and entered the resident's room.
-Resident #1 was sitting on the edge of his bed with his left forearm held in front of his chest with 5 streams of blood running down his wrist.
-There were 12 various sizes of blood drops on his bedroom floor in between his feet where the blood from his wrist had dripped to the floor.
-The surveyor called for the SIC to come assist Resident #1 that it was an emergency.
-The SIC came into the resident's room and sat on the edge of the bed beside him.
-The SIC asked the resident why he cut himself and why did he not come to talk with her.
-She explained to the resident that he was supposed to talk with her if he was feeling suicidal.
-The surveyor asked the SIC to go get supplies to place compression on the resident's wrist and to call 911.
-The SIC applied numerous brown paper towels to the resident's left wrist and reminded him to continue to apply pressure to the wounds.
-There was a disposable razor sitting on top of books on a nightstand to the beside the resident's bed.

Third observation of Resident #1 on 10/16/24 at 12:09pm revealed:
-He sat on the front porch with the SIC standing beside him as he waited for emergency medical

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services (EMS) to arrive.
-He continued to apply pressure with the brown paper towels to his left wrist.
-The SIC/MA did not provide first aid to the resident.

Second interview with Resident #1 on 10/16/24 at 12:09pm revealed:
-He hid two disposable razors in the yard on the side of the facility.
-He cut his wrists in his bedroom because he "just felt like it."
-He felt agitated and irritable and just started cutting his left wrist.
-He stated that he did not want to live any longer.

Interview with an EMS worker on 10/16/24 at 12:14pm revealed Resident #1 had six cuts to his left wrist.

Interview with the SIC on 10/16/24 at 12:23pm revealed:
-She could not hear Resident #1 calling for help from his bedroom earlier today.
-She shut her bedroom door sometimes, she could not remember why she had her bedroom door shut when Resident #1 called for help.
-Resident #1 usually stayed busy, he talked a lot at the facility and walked outside to smoke cigarettes frequently.
-Resident #1 had not communicated to her that he felt suicidal on 10/16/24 or earlier in the week.

Observation of the Administrator on 10/16/24 at 2:08pm revealed:
-The Administrator was on the telephone and explained to the person on the other end that the facility had not been able to get Resident #1 an appointment for mental health services.
-He asked the person on the telephone if they

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C 211	Continued From page 15 could advocate for Resident #1 to get a mental health appointment scheduled because it did not look good for the facility. Interview with the Administrator on 10/16/24 at 2:10pm revealed: -Resident #1 was scheduled to have his first visit with a PCP today at 3:20pm. -He could not remember when he scheduled the resident's appointment with the PCP. -He took Resident #1 to a psychiatrist office, a mental health provider and a PCP on 09/17/24 and assisted him to complete the new registration for each provider. -The providers informed him that they would attempt to get in contact with the resident's guardian to finalize scheduling an appointment for Resident #1. -He had not been able to reach Resident #1's legal guardian, he had left the legal guardian a voicemail but had not heard back from the resident's legal guardian. -He could not remember what date he left a voicemail for the resident's legal guardian. -He made efforts to attempt to obtain mental health services for Resident #1 and he was scheduled for his first visit with his PCP today (10/16/24) at 3:20pm. -He provided transportation to Resident #1 on 09/17/24 to assist the resident complete registration forms for a local mental health provider, psychiatrist, and PCP. _____ The facility failed to make arrangements for Resident #1 to be evaluated by a licensed mental health provider, psychiatrist or primary care physician after being in an inpatient psychiatric hospital 29 days prior to admission to the facility for an IVC due to a suicide attempt with suicidal and homicidal ideations and auditory	C 211		

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C 211	Continued From page 16 hallucinations, the resident returned to the facility for 14 days, had a second suicide attempt with an IVC to an inpatient psychiatric hospital, the resident returned to the facility for 16 days and had a third suicide attempt and was transported to a local emergency department. This failure resulted in substantial risk for serious physical harm to Resident #1 and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 16, 2024, for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED November 16, 2024.	C 211		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.	C 257		

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C 257	Continued From page 17	C 257		

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure foods being stored and served to residents were protected from contamination related to observations of expired, unlabeled, and unsecured food.

The findings are:

Review of the facility's undated Nutrition and Food Service police revealed:
-The kitchen and dining areas should be kept clean, orderly, and protected from contamination.
-All food items should be properly stored, thawed, and prepared at the appropriate temperatures.

Observation of the side by side refrigerator in the facility kitchen on 10/16/24 at 11:28am revealed:
-There were four shelves in the refrigerator and one drawer on the bottom.
-There were three compartments on the right side of the refrigerator door.
-There was a tube of 5 pounds (lbs.) of ground beef that was on the top shelf of the refrigerator.
-The ground beef was opened at one end with the open end of the tube inside a large storage bag.
-The other end of the ground beef tube stuck out of the storage bag.
-The ground beef was on top of a clear plastic package of cookies.
-There were 8 cookies in the clear plastic package with a sell by date of 07/10/24.
-The count of cookies labeled in the clear plastic package were 16 cookies.
-There were six 2.75 ounce (oz) packages of apple slices with peanut butter in two separate

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C 257	Continued From page 18 compartments of the package on the top shelf to the left of the ground beef. -The packages of apple slices with peanut butter had an expiration date of 08/26/24. -The apple slices were slimy and wilted. -The second shelf of the refrigerator had two opened 11 oz mixed salad bags, the lettuce was slimy and had dark green and brown discoloration. -There was a 7 oz opened bag of potato chips that was folded over at the top of the bag to the middle of the bag that was not secured properly. -There was one head of cauliflower on the fourth shelf that had spots of brown and green mold. -There were four plastic bags of romaine lettuce in the bottom drawer with a sticker imprinted with harvested on 09/21/24. -The romaine lettuce in the four plastic bags was discolored with brown and dark green, wilted and slimy leaves. -The second compartment on the refrigerator side door had one half of a small onion sitting on a canned food item, exposed with no protection from contamination. -There were two opened 6 oz cans of tomato paste with the lid opened and a small section of the lid connected to the can. -There were four shelves in the freezer. -The second shelf had an opened 12 oz package of link sausages with four in the pack of 10 remaining. -There was an opened 5 lb. bag of chicken drumsticks that was not secured from contamination. -There was a 32 oz bag of fish nuggets that were not properly secured, with the top of the plastic bag opened. Interview with the Supervisor in Charge (SIC) on 10/16/24 at 11:40am revealed:	C 257		

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C 257	Continued From page 19 -She was responsible for storing food properly at the facility. -She had been busy and forgot to properly secure opened food items appropriately. -A resident had purchased the tube of ground beef. -She had placed the open portion of the tube of ground beef in a storage bag and made the mistake of placing the raw ground beef on the top shelf of the refrigerator. -She had not noticed that there were several items in the refrigerator that had expired and were no longer safe for residents to consume. Interview with the Administrator on 10/17/24 at 5:20pm revealed: -The SIC was responsible for properly storing foods at the facility. -He was not aware that there were expired items in the refrigerator that were not appropriate for residents to consume. -Raw ground beef should have been properly stored in the refrigerator below other items to prevent contamination of other foods. -The SIC should ensure that foods were stored properly at the facility and any expired food items should be discarded.	C 257		
C 271	10A NCAC 13G .0904(d)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition And Food Service (d) Food Requirements in Family Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours	C 271		

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C 271	Continued From page 20 between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide 2 of 3 sampled residents with a minimum of three nutritionally adequate meals a day. The findings are: Review of the facility's undated House Policies revealed: -The facility would serve three scheduled meals daily, breakfast, lunch, and dinner with snacks provided. -All meals served would be nutritious and balanced. Review of the facility's handbook of services offered revealed three nutritionally balanced meals would be served daily with three snacks offered between meals and with the resident's preferences taken into consideration. Observation of breakfast served on 10/16/24 at 8:45am revealed: -There were two residents who were served breakfast. -Both residents were served one slice of toast and one scrambled egg. -Coffee was the only beverage the residents had with their breakfast. -A third resident did not want to eat breakfast and sat on the couch.	C 271		

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C 271	Continued From page 21 Interview with a resident on 10/16/24 at 8:57am revealed: -He usually preferred to only eat lunch and dinner. -He usually bought some food items from the grocery store a few times a month to have at the facility. Observation of a second resident on 10/16/24 at 12:07pm revealed: -The resident sat at the dining room table and ate a small bowl of canned pasta. -There was a small amount of the canned pasta that had spilled on the kitchen floor. Interview with a second resident on 10/16/24 at 12:08pm revealed: -She was hungry and prepared a small bowl of canned pasta to eat. -She opened the can with a manual can opener and heated the canned pasta in the microwave. Interview with a third resident on 10/16/24 at 9:18am revealed: -Another resident prepared coffee that morning and served her coffee with her breakfast. -Sometimes she was hungry because she was not provided with enough food at meals. -She would ask the Supervisor in Charge (SIC) for food when she felt hungry. Observation of breakfast served on 10/17/24 at 8:30am revealed: -One resident was served a bowl of oatmeal, one slice of toast and coffee. -There was 1 resident present in the dining room. -The other 2 residents were not at the facility. -The resident in the dining room was served a bowl of oatmeal, one slice of toast and coffee.	C 271		

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C 271	Continued From page 22 Interview with the SIC on 10/16/24 at 8:50am revealed: -The residents usually preferred to eat a small breakfast. -She was responsible for preparing meals for the residents at the facility. -She forgot that she should have served fruit with breakfast. -The residents preferred coffee with their breakfast. -There was not any milk at the facility except for one gallon that was in the freezer. -She rarely served milk or juice to residents at breakfast. Interview with the Administrator on 10/17/24 at 5:20pm revealed: -He and the SIC tried to accommodate the resident's preferences with food choices. -He became frustrated when he observed resident's throw away portions of their meal and drinks. -The SIC was responsible for preparing meals at the home. -He was not aware that residents were only served one slice of toast and one scrambled egg for breakfast on 10/16/24. -He expected the SIC to prepare an appropriate balanced meal for residents.	C 271		
C 273	10A NCAC 13G .0904(d)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025, which are hereby incorporated by reference, including	C 273		

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C 273	Continued From page 23 subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf, at no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dairy products were served three times daily to residents. The findings are: Review of the facility's undated House Policies revealed: -The facility would serve three scheduled meals daily, breakfast, lunch, and dinner with snacks provided. -All meals served would be nutritious and balanced. Review of the facility's handbook of services offered revealed three nutritionally balanced meals would be served daily with three snacks offered between meals and with the resident's preferences taken into consideration. Interview with the Supervisor in Charge (SIC) on 10/16/24 at 8:00am revealed:	C 273		

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C 273	Continued From page 24 -The facility had a current census of 4 residents. -One of the four residents were in the hospital. Observation of the facility's daily menu on 10/16/24 at 8:34am revealed: -There was no date on the posted menu. -Milk was not listed to be served for breakfast, lunch, or dinner meal services. -Pudding was listed as a snack to be served after lunch. -There were no other equivalent dairy products listed on the menu to be served. Observation of the kitchen on 10/16/24 at 8:15am revealed there was no milk in the refrigerator. Observation of the kitchen on 10/17/24 at 10:37am revealed there was one gallon of milk in the freezer that had not been opened. Observation of the breakfast meal service on 10/16/24 at 8:43am revealed: -There were 2 residents present in the dining room. -One resident made the other resident's coffee and served them coffee. -The 2 residents at the dining room table drank coffee. -No milk or other dairy product were served at breakfast. -Both residents were served one slice of toast and one scrambled egg. Interview with the Supervisor in Charge (SIC) on 10/16/24 at 8:50am revealed: -The residents preferred coffee with their breakfast. -There was not any milk in the refrigerator that could be served at breakfast. -One resident liked to have a soft drink with her	C 273		

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C 273	Continued From page 25 breakfast and coffee. -She was not aware that the facility was required to serve 8 ounces of milk or other equivalent dairy products with breakfast, lunch and dinner. -She thought a resident had purchased milk last month and placed it in the freezer. Interview with a resident on 10/16/24 at 8:57am revealed: -He usually preferred to only eat lunch and dinner. -He bought milk and brought it to the facility sometime last month. -He usually bought some food items from the grocery store a few times a month to have at the facility. Interview with a second resident on 10/16/24 at 9:18am revealed: -Another resident prepared coffee that morning and served her coffee with her breakfast. -She asked another resident for a canned soft drink to have with her breakfast because she wanted something to drink in addition to her coffee. -She could not remember when she was last served milk at the facility. -She liked milk and would enjoy having milk with her meals. Observation of the breakfast meal service on 10/17/24 at 8:30am revealed: -There was 1 resident present in the dining room. -The other 2 residents were not at the facility. -The resident in the dining room was served coffee. -No milk or other dairy product was served at breakfast. -One resident was served a bowl of oatmeal, one slice of toast and coffee.	C 273		

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C 273	Continued From page 26 Interview with the Administrator on 10/17/24 at 5:20pm revealed: -He tried his best to accommodate what types of food and drinks the residents preferred at meals. -He was not sure when he or the SIC had last purchased milk for the facility. -The residents often threw their meals and drinks in the trashcan, and they wasted food and drinks.	C 273		
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 observation, interviews, and record reviews the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Review of the facility's undated Activity policy revealed: -The facility would develop a program of activities designed to promote the resident's active involvement with each other, their families, and the community. -All activities would be developed based on information obtained about each resident's interests and capabilities. -A minimum of 14 hours of group activities should be planned each month to help promote socialization, physical interaction, group	C 288		

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accomplishment, creative expression, increased knowledge and the learning of new skills.
-A monthly calendar of activities should be posted for all resident's and staff to view.
-Staff should encourage all residents to participate in activities, assure there are adequate supplies, appropriate supervision if assistance was needed to participate, document all resident's participation and evaluate the effectiveness of the activities program every six months.

Review of the facility's undated House Policies revealed recreation and entertainment in and out of town would be scheduled for the resident's enjoyment.

Interview with the Supervisor in Charge (SIC) on 10/16/24 at 8:00am revealed:
-The facility had a current census of 4 residents.
-One of the four residents were in the hospital.
-The three residents at the facility did not attend a day program.
-The residents usually watched television, smoked outside and listened to music.

Observation of the facility on 10/16/24 at 8:34am revealed:
-There was an activity calendar posted on the bulletin board wall in the hallway by the kitchen that led to the back porch.
-The date on the activity calendar was July.
-The activity calendar had a psychosocial rehabilitation (PSR) activity listed each Monday through Friday from 8:00am to 3:00pm.
-There were two hours of activities listed each Monday through Saturday, and four hours listed for each Sunday.
-There was no other activity calendar posted in the facility.

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C 288	Continued From page 28 Second interview with the SIC on 10/16/24 at 8:33am revealed none of residents that resided at the facility attended a PSR program. Observations at the facility intermittently on 10/16/24 from 7:45am to 5:15pm revealed: -One resident sat on the couch and read a book from 9:00am until 9:10am, returned to his bedroom, went outside several times to smoke a cigarette and came back to the couch and listened to music at 10:53am. -A second resident laid on her bed in her bedroom from 9:00am to 9:15am, sat on the couch in the family room and returned to her bedroom at 10:55am. -The SIC at 11:18am asked the second resident to go to her bedroom and take a nap and reminded the resident to take her shoes off because her feet were on the couch and the SIC wanted to keep the facility clean. -The second resident continued to sit on the couch in the family room and did not go to her bedroom to take a nap. -A third resident sat on the couch in the family room from 9:00am to 9:20am, went outside several times to smoke a cigarette and came back to sit on the couch in the family room. Observation of the second resident on 10/16/24 at 2:03pm and 2:07pm revealed: -She asked the Administrator if he would play country music for her. -The SIC turned on music in the family room at 2:07pm. Second observation of the second resident on 10/16/24 at 4:30pm revealed she sat on the couch in the family room and stated loudly "I'm so bored."	C 288		

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C 288	Continued From page 29 Interview with the second resident on 10/16/24 at 8:50am revealed she wanted to go to school because she was bored at the facility. Interview with a third resident on 10/16/24 at 8:57am revealed: -He had been cooking at the facility because he got bored most days. -There were not any activities at the facility for the residents to patriciate in and he smoked cigarettes to pass the time. -He stayed in her room a lot because he was bored. -He listened to music with his on in the family room and on the back deck. Observations of a resident at the facility intermittently on 10/17/24 from 9:31am to 10:35am revealed: -At 9:31am, the resident who was seated on a couch in the family room yelled, "I'm bored, I'm a hostage." -At 9:50am, the resident asked the Administrator if he would go get her cigarettes so "I can have something to do." -At 10:16am, the resident asked the Administrator when he would go get her cigarettes, "it's bored just sitting here." -At 10:21am, the resident asked the SIC if she would play country music for her. -At 10:24am, she asked the SIC, "please play country music." -At 10:28am, she cried and said she missed a family member, the SIC had not turned on any music for the resident. -At 10:35am, the resident told the SIC that she wanted to listen to country music. Observations of the facility intermittently on	C 288		

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C 288	Continued From page 30 10/17/24 from 8:15am to 6:15pm revealed the only activities provided for residents included watching television and listening to music. Interview with the SIC on 10/17/24 at 8:30am revealed: -There was only resident at the facility today. -She would probably ask the resident if she wanted to play cards. -There were a few activity supplies at the facility, but residents usually liked to watch television, listen to music or rest. -She was not sure where an updated activity calendar was for the facility. Interview with the Administrator on 10/17/24 at 6:00pm revealed: -There was not an activity calendar for the month of October 2024 because he overlooked posting one. -He offered many activities to the residents at the facility which included card games, listening to music, dancing to music and going to the library. -He was not aware that the residents were not provided with planned activities on 10/16/24 or 10/17/24.	C 288		
C 299	10A NCAC 13G .0906 (d) Other Resident Services 10A NCAC 13G .0906 Other Resident Services (d) Telephone. (1) A telephone must be available in a location providing privacy for residents to make and receive a reasonable number of calls of a reasonable length; (2) A pay station telephone is not acceptable for local calls; and	C 299		

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C 299	Continued From page 31 (3) It is not the home's obligation to pay for a resident's toll calls. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure residents had access to a telephone in a private location for residents to make and receive telephone calls. The findings are: Review of the facility's Declaration of Resident's Rights revealed residents should have the right to have access to a telephone at a reasonable hour where the resident may speak privately. Review of the facility's undated Resident Bill of Rights policy revealed: -Residents should have access at any reasonable hour to a telephone where the resident can speak privately. -It was important that residents had a link to relatives, friends, and the outside world that the telephone provided. -Reasonable hours should be interpreted to mean working hours, normally the facility staff were busy during the first part of the morning hours, after 10:00am and before 8:00pm should in most cases be considered reasonable hours to use the telephone. Review of the facility's undated miscellaneous policy revealed: -Residents were allowed to make up to three telephone calls per day, unless prior arrangements were made, each telephone call lasting up to 10 minutes in length.	C 299		

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C 299	Continued From page 32 -No telephone calls should be made or received after 9:00pm, unless an emergency occurred. Interview with the Supervisor in Charge (SIC) on 10/16/24 at 8:00am revealed: -The facility had a current census of 4 residents. -One of the four residents were in the hospital. Observation of the facility on 10/16/24 at 8:53am revealed: -There was a telephone on a desk beside the couch in the family room. -The family room, desk and kitchen were an open area in the facility. -There was not a second telephone observed in the facility for residents to use. Interview with a resident on 10/17/24 at 8:47am revealed: -She was angry and upset that the SIC would not allow her to continue her telephone call with a family member earlier this morning. -She reported that the SIC disconnected her telephone call when she was speaking with a family member because residents were not allowed to use the telephone until after 5:00pm. -She wanted to speak with her family member every day because it helped her feel better when she spoke with her family member. Interview with the SIC on 10/17/24 at 8:52am revealed: -The resident did not dial her family members number this morning, the resident made random calls. -She disconnected the call this morning because the resident had called a random telephone number. -She was not able to explain how she knew the resident had called a random telephone number.	C 299		

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C 299	Continued From page 33 -Residents were allowed to use the telephone on the desk after 5:00pm because "it feels better to do after 5:00pm because people are off work." -Residents were able to use the telephone if they had an emergency anytime. Observation of the facility intermittently on 10/17/24 from 9:03am to 10:19am revealed: -The SIC left the kitchen, went into her bedroom. -The resident who was upset earlier this morning (10/17/24) that the SIC disconnected her telephone call to her family member went to the desk where the telephone was located. -The resident called her family member and left a voicemail and explained that she had already been to heaven. -The resident made a second telephone call at 9:06am and left a voicemail that she explained she was being held hostage, she provided her height and weight and reported that she was out of cigarettes. -At 9:09am, the SIC returned to the family room and asked the resident to leave the desk and sit on the couch in the family room. -At 10:19am, the Administrator left the facility, and the resident was in the family room and the SIC was at the back of the facility. -At 10:19am, the resident made a telephone call and left a voicemail that she was being held hostage, she did not have a television, an electronic tablet, or a telephone. Interview with the Administrator on 10/17/24 at 6:05pm revealed: -Residents were allowed to use the facility telephone between the hours of 5:00pm and 8:00pm. -The telephone that was available for residents to use was located on the desk in the family room and kitchen area.	C 299		

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C 299	Continued From page 34 -If a resident needed privacy, they could ask staff and other residents to give them a few minutes to speak privately with the individual they called. -Residents were allowed to make telephone calls before 5:00pm, however he preferred for residents to make any telephone calls between the hours of 5:00pm and 8:00pm.	C 299		
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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 sampled residents for medications to treat nausea, pain, and for smoking cessation (#1), a medication used to manage schizophrenia (#2), and a medication used to treat bipolar disorder (#3). The findings are: Review of the facility's undated House Policies revealed all medications should be administered by staff members trained as a medication aide (MA) according to the direction and written order of the primary care physician (PCP).	C 330		

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C 330	Continued From page 35 Review of the facility's undated Medication Administration policy revealed: -Routine doses should be recorded in accordance with the instructions for completing the medication administration record (MAR). -Doses not administered should be noted as circles at the appropriate time slot on the MAR with an explanation given on the back of the MAR of why the dose was omitted. -All medications should be noted on the resident's MAR by recording the name of the drug administered, dosage, hour of administration and initials of person administering the medication. 1. Review of Resident #1's current FL-2 dated 08/22/24 revealed: -Diagnosis included schizoaffective disorder-bipolar type. -There was an order for Domperidone 10mg every day at 8:00am (Domperidone is a medication used to treat nausea and vomiting). Review of Resident #1's Resident Register revealed the resident was admitted on 09/09/24. Review of Resident #1's September 2024 medication administration record (MAR) revealed: -There was an entry for Domperidone 10mg once a day, scheduled for administration at 8:00am. -Domperidone 10mg was documented as administered at 8:00am on 09/31/24 (There are only 30 days in the month of September). Review of Resident #1's October 2024 MAR revealed: -There was an entry for Domperidone 10mg once a day, scheduled for administration at 8:00am. -Domperidone was not documented as administered. -There was a line drawn diagonally where	C 330		

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documentation of administration of Domperidone would have been documented.

Observation of Resident #1's medications on hand on 10/16/24 at 3:22pm revealed there was no Domperidone available to administer to the resident.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/17/24 at 3:15pm revealed:
-The pharmacy was not able to dispense Domperidone.
-The resident's primary care provider (PCP) had to contact the Food and Drug Administration (FDA) to obtain a form to complete the prescription.
-The pharmacy printed on the resident's MAR that the facility's contracted pharmacy would not provide Domperidone.

Interview with Resident #1 on 10/16/24 at 9:05am revealed:
-He was not sure of the names of all his medications.
-He thought he received all his medications in the mornings and before bedtime.

Interview with the Supervisor in Charge (SIC) on 10/17/24 at 2:32pm revealed:
-She was not sure why Domperidone was not on the medication cart and available for Resident #1.
-She had not realized that the facility's contracted pharmacy did not fill prescription order.
-She was not sure why the Administrator documented Domperidone was administered to Resident #1.

Interview with the Administrator on 10/16/24 at 2:10pm revealed:

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C 330	Continued From page 37 -Resident #1 was scheduled to have her first visit with a PCP on 10/16/24 at 3:20pm but the resident had to go to the emergency room on 10/16/24 for cutting her wrist. -He was not aware that the facility's contracted pharmacy was not able to fill Resident #1's prescription for Domperidone. -He was not sure why he had initialed that Domperidone was administered to Resident #1 in September 2024. -He thought that Resident #1 came to the facility with some medications after she was discharged from an inpatient psychiatry hospital. -He did not have a record of the name, dose, frequency or quantity of Domperidone if the resident was discharged with Domperidone from the inpatient psychiatry hospital. b. Review of Resident #1's current FL-2 dated 08/22/24 revealed there was an order for Ibuprofen 200mg tablets, take one tablet every 4 to 6 hours as needed for pain. Review of Resident #1's September 2024 medication administration record (MAR) revealed: -There was an entry for Ibuprofen 200mg tablets, take one tablet every 4 to 6 hours as needed for pain. -Ibuprofen 200mg was documented as administered once daily on 09/18/24 and 09/19/24. -There were 2 Ibuprofen 200mg tablets documented as administered to Resident #1 once a day on 09/18/24 and 09/19/24. Review of Resident #1's October 2024 MAR revealed: -There was an entry for Ibuprofen 200mg tablets, take one tablet every 4 to 6 hours as needed for pain.	C 330		

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C 330	Continued From page 38 -Ibuprofen 200mg was documented as administered once a day from 10/01/24 through 10/04/24, and once a day on 10/07/24 and 10/08/24. -There were 6 Ibuprofen 200mg tablets documented as administered to Resident #1 once a day from 10/01/24 to 10/04/24 and from 10/07/24 to 10/08/24. Observation of Resident #1's medications on hand on 10/16/24 at 3:22pm revealed Ibuprofen 200mg was not available to administer to the resident. Second observation of Resident #1's medications on hand on 10/17/24 at 2:30pm revealed Ibuprofen 200mg was in bubble card from the facility's contracted pharmacy with a dispense date of 09/16/24 for a quantity of 30 with 11 tablets available to administer. Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/17/24 at 3:15pm revealed the pharmacy dispensed 30 tablets of Ibuprofen 200mg for Resident #1 on 09/16/24. Interview with Resident #1 on 10/16/24 at 9:05am revealed: -He knew he took something for pain a few times a month but could not remember the name. -He could not remember the last time the SIC or the Administrator had administered him pain medication. Interview with the Supervisor in Charge (SIC) on 10/17/24 at 2:32pm revealed: -Resident #1's Ibuprofen 200mg bubble card was in her bedroom on 10/16/24. -She had the Ibuprofen in her room because the	C 330		

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pharmacy delivery driver was scheduled to pick up the medication the evening of 10/16/24.
-The pharmacy delivery driver did not come to the facility the evening of 10/16/24 to pick up medications.
-She could not remember when she called to request the pharmacy delivery driver to pick up the Ibuprofen from the facility.
-She did not have a return form completed to return the medication to the pharmacy for the Ibuprofen.
-She should Ibuprofen 200mg bubble card on the medication cart and not in her bedroom.

Interview with the Administrator on 10/17/24 at 3:40pm revealed:
-He was not sure why the SIC had Resident #1's Ibuprofen in her room.
-Medications should always stay on the medication cart and the Ibuprofen should not have been in the SICs room.
-He was not aware that the SIC had planned to return Resident #1's Ibuprofen to the pharmacy because the resident needed the medication for pain at times.
-The facility's contracted pharmacy mailed the facility a return form after the facility sent medications back to the pharmacy.
-He was unable to locate any return forms of medications sent back to the pharmacy.

2. Review of Resident #2's current FL-2 dated 08/13/24 revealed:
-Diagnosis included schizophrenia.
-There was an order for Clozapine 50mg three times a day at 8:00am, 12:00pm, 4:00pm and 8:00pm (Clozapine is a medication used to treat schizophrenia).

Review of Resident #2's Resident Register

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C 330	Continued From page 40 revealed the resident was admitted on 09/09/24. Review of Resident #2's September 2024 medication administration record (MAR) revealed: -There was an entry for Clozapine 50mg tablet, take one tablet three times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm for schizophrenia. -Clozapine 50mg was not documented as administered on 09/10/24 at 8:00am, 12:00pm, and 4:00pm. -Clozapine 50mg was not documented as administered on 09/11/24 at 12:00pm, 4:00pm, and 8:00pm. -Clozapine 50mg was not documented as administered from 09/12/24 to 09/23/24 at 8:00am, 12:00pm, 4:00pm, and 8:00pm. Review of a physician order dated 09/24/24 revealed an order for Clozapine 100mg take twice a day at 8:00am and 8:00pm. Review of Resident #2's September 2024 MAR revealed: -There was an entry for Clozapine 50mg tablet, take one tablet three times a day at 8:00am, 12:00pm, 4:00pm, and 8:00pm for schizophrenia. -There was no entry for Clozapine 100mg, take twice a day at 8:00am and 8:00pm. -Clozapine 50mg was documented as administered on 09/26/24 at 8:00am, 12:00pm, and 4:00pm. -Clozapine 50mg was documented as administered on 09/27/24 at 8:00am, 12:00pm, and 4:00pm. Review of Resident #2's October 2024 MAR revealed: -There was an entry for Clozapine 100mg take twice a day at 8:00am and 8:00pm. -There was an entry of with the letter "F"	C 330		

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documented from 10/01/24 to 10/15/24 indicating the resident was out of the facility.

Observation of Resident #2's medications on hand on 10/16/24 at 3:22pm revealed Clozapine 100mg was not available to administer to the resident.

Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/17/24 at 3:15pm revealed the pharmacy dispensed 60 tablets of Clozapine 100mg for Resident #2 on 09/26/24 for a 30 day supply.

Interview with the Supervisor in Charge (SIC) on 10/17/24 at 2:32pm revealed:
-She was not sure why Clozapine 100mg was not on the medication cart and available to administered to Resident #2.
-She did not realize that she continued to administer Resident #2's 50mg of Clozapine four times a day after the resident's prescription was changed.
-She was not sure where the resident's Clozapine 100mg bubble card was because it was not located on the medication cart where it was supposed to be stored.

Interview with the Administrator on 10/17/24 at 3:40pm revealed:
-He was not sure why Resident #2's Clozapine was not on the medication cart.
-There was a possibility that the Clozapine was delivered to one of his other facilities by mistake and they had not realized it yet.
-He was not sure if Resident #2's Clozapine was returned the evening of 10/16/24 to the facility's contracted pharmacy by mistake.
-He did not have any documentation of medications returned to the facility's contracted

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C 330	Continued From page 42	C 330		

pharmacy.
-Resident #1 should have received her medications as ordered because it was the facility's responsibility to ensure medications were administered as ordered.

Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.

3. Review of Resident #3's current FL-2 dated 08/22/24 revealed diagnoses included bipolar disorder and schizophrenia.

Review of a physician order dated 08/29/24 revealed there was an order for Depakote ER 500mg, every evening at 8:00pm (Depakote ER is a medication used to treat bipolar disorder).

Observation of Resident #3 on 10/16/24 at 11:05am revealed she talked with the SIC and reported that she was going to visit her family.

Observation of the facility intermittently on 10/17/24 from 8:15am to 9:33am revealed Resident #3 was not at the facility.

Interview with the Supervisor in Charge (SIC) on 10/17/24 at 8:17am revealed that Resident #3 had not returned to the facility yet from her visit with family yesterday.

Observation of Resident #3 on 10/17/24 at 9:33am revealed the resident returned to the facility.

Interview with Resident #3 on 10/17/24 at 9:40am revealed:
-She was not at the facility the evening of 10/16/24 and did not receive her Depakote.

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C 330	Continued From page 43 -The SIC did not provide her with medications to take the evening of 10/16/24 before she left to stay with family. Review of Resident #3's October 2024 medication administration record (MAR) revealed: -There was an entry for Depakote ER 500mg take one tablet at 8:00pm for mood. -Depakote ER 500mg was not documented as administered at 8:00pm on 10/16/24. Interview with the Supervisor in Charge (SIC) on 10/17/24 at 2:32pm revealed: -She did not administer Resident #3 her Depakote ER because the resident was still with family the evening of 10/16/24. -She did not send Depakote ER with Resident #3 when she left to visit her family on 10/16/24. Interview with the Administrator on 10/17/24 at 3:40pm revealed: -He assumed Resident #3 would have returned to the facility by 8:00pm on 10/16/24. -He was not aware that Resident #3 had not returned to the facility and spent the night with family on 10/16/24. -Resident #3 needed her Depakote ER to help with her bipolar disorder. -The resident had not exhibited any behavioral problems; however, he expected staff to administer medications as ordered.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:	C 342		

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C 342	Continued From page 44 (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, interviews, and record reviews, the facility failed to ensure medication administration records were complete and accurate for 2 of 3 sampled residents (#1, #3). The findings are: Review of the facility's undated Medication Administration policy revealed: -Routine doses should be recorded in accordance with the instructions for completing the medication administration record (MAR). -Doses not administered should be noted as circles at the appropriate time slot on the MAR with an explanation given on the back of the MAR of why the dose was omitted. -All medications should be noted on the resident's MAR by recording the name of the drug administered, dosage, hour of administration and initials of person administering the medication.	C 342		

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C 342	Continued From page 45 1. Review of Resident #1's current FL-2 dated 08/22/24 revealed: -Diagnosis included schizoaffective disorder-bipolar type. -There was an order for Domperidone 10mg every day at 8:00am (Domperidone is a medication used to treat nausea and vomiting). Review of Resident #1's September 2024 medication administration record (MAR) revealed: -There was an entry for Domperidone 10mg once a day, scheduled for administration at 8:00am. -Domperidone 10mg was documented as administered at 8:00am from 09/12/24 to 09/23/24 and 09/31/24. Review of Resident #1's October 2024 MAR revealed: -There was an entry for Domperidone 10mg once a day, scheduled for administration at 8:00am. -Domperidone was not documented as administered. -There was a line drawn diagonally where documentation of administration of Domperidone would have been documented. -There was white out on 10/01/24 to 10/03/24 at 8:00am. Observation of Resident #1's medications on hand on 10/16/24 at 3:22pm revealed there was no Domperidone available to administer to the resident. Telephone interview with a pharmacist with the facility's contracted pharmacy on 10/17/24 at 3:15pm revealed: -The pharmacy was not able to dispense Domperidone. -The resident's primary care provider (PCP) had	C 342		

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to contact the Food and Drug Administration (FDA) to obtain a form to complete the prescription.
-The pharmacy printed on the resident's MAR that the facility's contracted pharmacy would not provide Domperidone.

Interview with Resident #1 on 10/16/24 at 9:05am revealed:
-He was not sure of the names of all his medications.
-He thought he received all his medications in the mornings and before bedtime.

Interview with the Supervisor in Charge (SIC) on 10/17/24 at 2:32pm revealed she was not sure why the Administrator documented Domperidone was administered to Resident #1.

Interview with the Administrator on 10/16/24 at 2:10pm revealed:
-He was not sure why he had initialed that Domperidone was administered to Resident #1 in September 2024.
-He could not remember who applied white out to the October 2024 MAR from 10/01/24 to 10/03/24 where staff initials should be documented when a medication was administered.
-He could not remember who drew a diagonal line through the October 2024 MAR for Domperidone.
-Staff should document accurately on the MARS.

2. Review of Resident #3's current FL-2 dated 08/22/24 revealed diagnoses included bipolar disorder and schizophrenia.

Review of a physician order dated 08/29/24 revealed there was an order for Depakote ER 500mg, every evening at 8:00pm (Depakote ER is a medication used to treat bipolar disorder).

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C 342	Continued From page 47 Observation of Resident #3 on 10/16/24 at 11:05am revealed she talked with the SIC and reported that she was going to visit her family. Observation of the facility intermittently on 10/17/24 from 8:15am to 9:33am revealed Resident #3 was not at the facility. Interview with the SIC on 10/17/24 at 8:17am revealed that Resident #3 had not returned to the facility yet from her visit with family yesterday. Observation of Resident #3 on 10/17/24 at 9:33am revealed the resident returned to the facility. Interview with Resident #3 on 10/17/24 at 9:40am revealed she was not at the facility the evening of 10/16/24 and did not receive her Depakote. Review of Resident #3's October 2024 medication administration record (MAR) on 10/17/24 at 8:30am revealed: -There was an entry for Depakote ER 500mg take one tablet at 8:00pm for mood. -There was no documentation that Depakote ER 500mg was administered at 8:00pm on 10/16/24. Second review of Resident #3's October 2024 MAR on 10/17/24 at 9:52am revealed: -There was an entry for Depakote ER 500mg take one tablet at 8:00pm for mood. -There were staff initials on 10/17/24 indicating that Depakote ER 500mg was administered at 8:00pm on 10/16/24. Interview with the Supervisor in Charge (SIC) on 10/17/24 at 2:32pm revealed: -She did not administer Resident #3 her	C 342		

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C 342	Continued From page 48 Depakote ER because the resident was still with family the evening of 10/16/24. -She did not send Depakote ER with Resident #3 when she left to visit her family on 10/16/24. Interview with the Administrator on 10/17/24 at 3:40pm revealed: -He made a mistake when he documented on Resident #3's MAR that the resident received Depakote ER 500mg at 8:00pm on 10/16/24. -The resident missed one dose of her Depakote ER 500mg, however it was important to help her bipolar disorder that she was administered her medications as ordered.	C 342		