STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092309	A. BUILDING: _____ B. WING _____	R 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART TO HEART FAMILY CARE HOME 2	221 EAST BARBEE STREET ZEBULON, NC 27597

(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 12/23/24.	C 000		
C 236	10A NCAC 13G .0802 (a) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plans (a) A family care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan shall be an individualized, written program of personal care for each resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 3 sampled residents (#1, #3) had a care plan completed within 30 days of admission. The findings are: 1. Review of Resident #1's current FL2 dated 07/05/24 revealed: -Diagnoses included history of intellectual disability disorder, non-verbal and anxiety. -She was ambulatory. -She was continent of bowel and bladder. -There was no information on orientation. Review of Resident #1's Resident Register revealed she was admitted to the facility on 04/06/23. Review of Resident #1's record revealed there was no care plan available for review. A copy of Resident #1's current care plan was requested from the medication aide (MA) on	C 236		

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C 236	Continued From page 1 12/23/24 at 10:00am but was not provided. A copy of Resident #1's current care plan was requested from the Administrator on 12/23/24 at 10:45am but was not provided. Refer to interview with a MA on 12/23/24 at 11:30am. Refer to interview with the Administrator on 12/23/24 at 11:35pm. Attempted telephone interview with Resident #1's primary care provider (PCP) on 12/23/24 at 1:05pm was unsuccessful. 2. Review of Resident #3s current FL2 dated 05/08/24 revealed: -Diagnoses included history of schizoaffective disorder, hyperlipidemia, and benign essential hypertension. -She was ambulatory. -She was continent of bowel and incontinent of bladder. -She had intermittent disorientation. Review of Resident #3's Resident Register revealed she was admitted to the facility on 05/13/24. Review of Resident #3's record revealed there was no care plan available for review. A copy of Resident #3's current care plan was requested from the medication aide (MA) on 12/23/24 at 10:00am but was not provided. A copy of Resident #3's current care plan was requested from the Administrator on 12/23/24 at 10:45am but was not provided.	C 236		

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C 236	Continued From page 2 Refer to interview with a MA on 12/23/24 at 11:30am. Refer to interview with the Administrator on 12/23/24 at 11:35pm. Attempted telephone interview with Resident #3's primary care provider (PCP) on 12/23/24 at 1:05pm was unsuccessful. _____ Interview with a MA on 12/23/24 at 11:30am revealed: -She was not aware that Residents #1 and #3 did not have care plans in their records. -The Administrator was responsible for ensuring care plans were available in resident records. Interview with the Administrator on 12/23/24 at 11:35pm revealed: -She was aware that Residents #1 and #3 did not have a care plan in their records. -She was having difficulty getting the care plans for Residents #1 and #3 signed by the primary care provider. -She was responsible for ensuring all residents had a care plan upon admission. -She audited the resident records monthly.	C 236		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;	C 342		

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C 342	Continued From page 3 (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records (MAR) were accurate for 1 of 3 sampled resident (#3) related to the documentation of a medication used to treat schizophrenia. The findings are: Review of Resident # 3's current FL2 dated 05/08/24 revealed diagnoses included schizoaffective disorder, hyperlipidemia and hypertension. Review of Resident #3's physician order dated 05/13/24 revealed an order for quetiapine (used to treat schizophrenia) 150mg, give one tablet by mouth daily at bedtime. Review of Resident #3's October 2024 MAR revealed there was no entry for quetiapine 150mg tablet.	C 342		

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C 342	Continued From page 4 Review of Resident #3's November 2024 MAR revealed: -There was a hand written entry for quetiapine 150mg tablet, give one tablet by mouth daily at bedtime. -Quetiapine 150mg tablet, give one tablet by mouth at bedtime was documented as administered on 11/01/24 through 11/30/24. Review of Resident #3's December 2024 MAR revealed there was no entry for quetiapine 150mg tablet. Observation of Resident #3's medications on hand 12/23/24 revealed: -Quetiapine 150mg was available on the medication cart. -There were 10 pills in the bottle. -On December 3, 2024 30 pills were dispensed. Interview with the Medication Aide (MA) on 12/23/24 at 10:30am revealed: -Resident #3 received quetiapine 150mg every night at 8:00pm for schizophrenia. -She had to write the quetiapine on Resident #3's MAR each month because it came from a seperate pharmacy than her other medications. -She forgot to write it on the MAR for the months of October and December. -She was responsible for writing Resident #3's quetiapine on the MAR each month. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 12/23/24 at 11:49am revealed: -Resident #3's quetiapine 150mg tablet was last dispensed on December 3, 2024 (30 tablets). -Resident #3's quetiapine 150mg tablet was also dispensed on October 29, 2024 (30 tablets).	C 342		

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C 342	Continued From page 5 -Resident #3's quetiapine 150mg tablet was also dispensed on September 29, 2024 (30 tablets). Interview with the Administrator on 12/23/24 at 12:35pm revealed: -The MA was responsible for filling out the MARs correctly. -The MA was responsible for adding Resident #3's quetiapine on the MAR each month. -She was responsible for auditing the MAR and comparing it to the medications on hand. -She audited the medications in December and did not realize that Resident #3's quetiapine was not on the MAR. Based on observations, record reviews and interviews of Resident #3 on 12/23/24, the resident was determined not to be interviewable. Attempted telephone interview with Resident #3's current primary care provider (PCP) on 12/23/24 at 1:05pm was unsuccessful.	C 342		