STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						R
		FCL032096	B. WING		01/3	31/2025
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES F	AMILY HOME		ERLAND DRI' , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{C 000})} Initial Comments		{C 000}			
	The Adult Care Licensure Section conducted a follow up survey on 01/28/25-01/31/25 with a telephone exit on 01/31/25.					
{C 078}	10A NCAC 13G .03 Furnishings	315(a)(5) Housekeeping and	{C 078}			
	Furnishings (a) Each family care (5) be maintained ir orderly manner, fre- hazards;	e home shall: n an uncluttered, clean and e of all obstructions and ly to new and existing homes.				
		N ons and interviews, the facility				
	manner, and free o	ned in a clean and orderly f hazards, related to live and erved in a resident's bedroom oaches observed in the dining				
	The findings are:					
	Inspection report da -There were 9 total -Demerits included repair, walls, ceiling repair, handwashing presence.	ty's Environmental Health ated 01/06/25 revealed: demerits. floors and carpet in good gs, and attachments in good g provided, and pest e present in a residential care				

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

TITLE (X6) DATE

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		FCL032096	B. WING		01/3	1/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI , NC 27704	VE		
		ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
{C 078}	Continued From pa	ge 1	{C 078}			
	facilityBe sure to remove harborage.	dead pests to prevent				
		ne dining room on 01/28/25 at ultiple dead roaches on the eside the table.				
	Interview with 3 residents on 01/28/25 from 8:12am-8:25am revealed they had observed both dead and live roaches in the dining room.					
	Observation of the dining room on 01/28/25 at 5:50pm revealed multiple dead roaches were on the floor beside the table and had not been cleaned up.					
	Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 3:26pm revealed: -He had seen roaches in the dining roomHe had not told the Director he had seen live roaches because he assumed the Director had seen them.					
	the facility's contract 01/18/25 at 12:44pi -The facility had not their company. -The facility had not -The facility could be	w with a representative from sted pest control company on m revealed: t been treated for roaches by t requested pest treatment. The treated for roaches, but the request pest treatment.				
	8:25am revealed: -She saw live and control of the saw live	Ith Specialist on 01/29/25 at lead roaches at the facility on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			₹
		FCL032096	B. WING		I	31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	FAMILY HOME		RLAND DRI , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{C 078}	live roaches ate live -Not cleaning up de harborage (in pest of the locations and colive, thrive, and repiRoaches would ke cleaned up. Telephone interview 01/29/25 at 9:44am -He had seen roach then." -The staff had been [named] spray that residentsHe could not make control companyThe staff working of Telephone interview at 10:32am reveale -The staff had been roachesHe used a [named treat the roachesHe thought the spr roaches had been " -He had not called to treat the roachesHe had not read th dated 01/06/25Cleaning the facilit clean up dead pest -If the SIC did not co 01/28/25, it was pro "nervous" because facility.	es ones. ead pests was considered control, harborage referred to conditions where pests could roduce). ep "coming around" if not w with the House Manager on revealed: hes at the facility, "now and harborage around the eather decision to use a pest usually sprayed at night. w with the Director on 01/29/25 do: harborage treating the facility for safe spray once a month to ray was working because the bad' but were getting better. The pest control company to the Environmental Health report y was an ongoing process to solean up the dead roaches on obably because he was the surveyor was in the	{C 078}			
		v with the facility's contracted er (PCP) on 01/29/25 at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	FCL032096	B. WING			R 31/2025	
NAME OF PROVIDER OR SUPPLIER JONES FAMILY HOME		DRESS, CITY, S				
JONES FAMILI HOME	I, NC 27704					
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
-Roaches carried dis She thought the faci professionally extern Telephone interview 01/29/25 at 12:24pm - The staff had not no roachesThe staff should haseen roaches. Telephone interview 01/30/25 at 9:57am SIC to clean up dead they saw them. According to the Uniterview of the	roaches at the facility. sease and were not sanitary. ility needed to be minated. with the Administrator on n revealed: otified her of the presence of we let her know they had with the Administrator on revealed she expected the d roaches daily, as often as ited States Environmental EPA) publication dated baches and their droppings ma attack. Their feces, saliva, g, or cuticles left behind on substances that were s, especially those with piratory conditions. Within of their bodies, roaches a could cause salmonella, d streptococcus if deposited in me interview with the //29/25 at 12:24pm. resident on 01/18/25 at 8:12am a two [named] residents who					

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STATE FORM 6899 QYIW12 If continuation sheet 4 of 77

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ECI 022006		B. WING		F 04/2	
NAME OF	PROVIDER OR SUPPLIER	FCL032096	I.		01/3	1/2025
	2122 OV			STATE, ZIP CODE VE		
JONES F	FAMILY HOME	DURHAM,	NC 27704			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 078}	Continued From pa	ge 4	{C 078}			
	8:15am revealed: -He had bed bugs in- The bed bugs craw- He had not been book the facility "fumed months back." -He did not like have the had bed bugs in- He had bed bugs in- He had been bitter it was a long time and the had been bitter it was a long time and the did not like have to be left-hand side of the right-hand side of the right-hand side of the right-hand side of the bed linen on the bed linen on the sidents' beds. Observation of a second/28/25 at 9:53am number of dead bug of the resident's bed liner on on or the bought his own since he had been had not seen any line.	itten by the bed bugs. " the facility a "couple of ing bed bugs in his bed. d resident on 01/28/25 at In his room. In by bed bugs in his room, but go, in the summer of 2024. Ing bed bugs. Iteresident's room on 01/28/25 at Iteresident's room on 01/28/25 at Iteresident's room, a bed on the itere room and a second bed on of the room. Iteresident's room on				

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QYIW12 If continuation sheet 5 of 77

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			71. BOILDING.		R	
		FCL032096	B. WING		1	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	JONES FAMILY HOME			VE		
	-		NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{C 078}	Continued From pa	ge 5	{C 078}			
{C 078}	Interview with the S 01/28/25 at 10:00ar -The pest control or come to the facility 01/30/25He did not know w was last at the facility He told the House bugs, and the House bugs, and the House He did not know w Manager, but it had started "back" work Telephone interview the facility's contract 01/18/25 at 12:44pr -The facility was tree 11/21/24They received a cast to reschedule the tree member was sick, a rescheduled for 01/2-They had not received bug activity prior to to the facility. Telephone interview Environmental Hea 8:25am revealed: -She did not see live the facilityBed bugs needed and cleaned up.	supervisor-in-Charge (SIC) on m revealed: ompany was scheduled to to treat the bed bugs on then the pest control company sity. Manager he had seen live bed se Manger said, "he knew." then he told the House been since 01/20/25 when he ing at the facility. With a representative from sted pest control company on m revealed: ated for bed bugs on all on 01/16/25 to treat bed neduled for 01/24/25. The facility eatment because a staff and the treatment was 30/25. The wed any calls about live bed 01/16/25. With the county of the facility of	{C 078}			
	facility two months	re of the bed bugs at the				

Division of Health Service Regulation

STATE FORM 6899 QYIW12 If continuation sheet 6 of 77

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		FCL032096	B. WING		01/3	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI' , NC 27704	VE		
(V4) ID	SLIMMARY STA			PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 078}	Continued From pa	ge 6	{C 078}			
	the hallway about 2 -The pest control or saw the bed bugs, I immediately and he -He was sick and h appointment as he needed to be at the the residents out of Telephone interview at 10:32am reveale bugs at the facility a					
	Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -The staff had not notified her of any live bed bugsShe was not aware the facility had active bed bugsThe staff should have let her know they had seen bed bugs. Telephone interview with the Administrator on					
	SIC to clean up dea they saw them. Telephone interview primary care provid 11:59am revealed: -Live bed bugs in the resident's risk for be- lf a resident was be- resident could scrar- resident at risk for a	itten by a bed bug, the tch the bite, which put the				
		Services guidelines dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
			B. WING			R	
		FCL032096	B. WING		01/3	31/2025	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
JONES F	FAMILY HOME		ERLAND DRI' , NC 27704	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
{C 078}	O78 Continued From page 7 March 2024 revealed bed bugs could cause skin		{C 078}				
	possible infection, a	d lead to scabbing and allergic reactions, and om skin irritation and lack of					
	Refer to the telepho 01/29/25 at 11:38ar	one interview with the SIC on n.					
	Refer to the telephone interview with the Administrator on 01/29/25 at 12:24pm.						
	Telephone interview with the SIC on 01/29/25 at 11:38am revealed: -He cleaned the facility every dayHe had not done pest control at the facilityHe swept the facility every morning and every eveningIf he saw dead pests, he swept them up.						
	01/29/25 at 12:24pr -The Director needs come out and treat -The facility needed -She was concerne	ed to have a pest company					
	environment free free roaches in the dining one resident's room and bed bugs in the residents' risk of diswas detrimental to the roaches.	ensure a clean and orderly om hazards related to dead g room and active bedbugs in a. Pests, including roaches a facility increased the sease and infections, which the health, safety, and welfare d constitutes a Type B					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7t. BOILDING.		R	
		FCL032096	B. WING		I	1/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI' , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 078}	Continued From pa	ge 8	{C 078}			
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 001/31/25 for this violation.					
		TE FOR THE TYPE B . NOT EXCEED MARCH 17,				
{C 100}	10A NCAC 13G .03 Disaster Plan	16 (e) Fire Safety And	{C 100}			
	10A NCAC 13G .03 Plan	16 Fire Safety And Disaster				
	fire evacuation plan rehearsals shall be furnished to the cou- services annually. date and time of the	at least four rehearsals of the each year. Records of maintained and copies unty department of social The records shall include the erehearsals, staff members t description of what the				
		ons, interviews, and record failed to ensure at least four				
	The findings are:					
		y's current license effective he facility was licensed for 6 ts.				
	Review of the facilit revealed:	y's fire drills documentation				

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DIVISION	of Health Service Re	egulation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	₹
		FCL032096	B. WING		01/3	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2122 OVE	RLAND DRIV	VE		
JONES I	FAMILY HOME	DURHAM	, NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 100}	Continued From pa	ge 9	{C 100}			
	drill in which all the evacuate the facility -There was docume drill in which all the evacuate the facility	entation of a completed fire residents were able to				
	Observation of a fire drill on 01/28/25 at 10:45am revealed: -There were four residents inside the facility, and one resident sitting on the outside porchAll the residents were able to evacuate the facility without staff assistance in less than three minutesThe residents met at the designated zone outside the facility.					
	Interview with a resident on 01/28/25 at 8:12am revealed: -Fire drills were rareHe could not recall the last time the facility had a fire drill, but it was before the holidays.					
	8:15am revealed: -It had been "severa	cond resident on 01/28/25 at all months since they had a d not recall exactly when. ot out okay."				
	8:17am revealed th	d resident on 01/28/25 at ey had a fire drill a "long time was back in the summer of				
	01/18/25 at 3:38pm	upervisor-in-Charge (SIC) on revealed:				

fire drill log and put it in the notebook.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
	FCL032096		B. WING		01/31/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	JONES FAMILY HOME 2122 OVE			VE .		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{C 100}	Continued From pa	ge 10	{C 100}			
	-He had not performed a fire drill at the facility since he started working at the facility on 01/20/25.					
	Telephone interview with the House Manager on 01/29/25 at 9:44am revealed: -All staff were responsible for performing fire drills at the facilityHe had not performed a fire drill at the facility in the last 3 months.					
	Telephone interview with the Director on 01/29/25 at 10:32am revealed: -The SIC and the House Manager were responsible for performing fire drills. -He had not performed a fire drill in the last 3 months. -When a fire drill was completed, it should be documented on the fire log. -There "used to be" a fire drill schedule.					
	01/30/25 at 9:57am	w with the Administrator on revealed the SIC was forming fire drills; a fire drill log ed.				
{C 131}	10A NCAC 13G .04 Medication Staff	03(a) Qualifications of	{C 131}			
	medications, herea aides, and their dire training, clinical skil written examination 131D-4.5B. Person occupational licens					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R	
		FCL032096	B. WING		01/3	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IONES FAMILY HOME			ERLAND DRIV I, NC 27704	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{C 131}	Continued From page 11		{C 131}			
	This Rule is not me Follow-Up to a Type The Type B Violation practice continues. Based on interview facility failed to ensure who administered in medication clinical documentation of a 15-hour medication she MA before administ The findings are:	et as evidenced by: e B Violation on was abated. Deficient s and record reviews, the ure 1 of 3 sampled staff (A) nedications, completed a skills checklist, and had completing the 5, 10, or aide (MA) training course or had previously worked as a tering medication to residents.				
	Review of Staff A's personnel record revealed: -There was no signed job description or hire dateThere was no medication clinical skills checklistThere was no certificate for the 5, 10, or 15-hour MA training course or verification she had previously worked as an MAThere was documentation that Staff A passed the written state medication administration examination on 12/16/16. Review of a resident's January 2025 medication administration record (MAR) from 01/01/25-01/28/25 revealed Staff A administered medications from 01/5/25-01/19/25. Interview with a resident on 01/28/25 at 8:12am revealed Staff A administered medications when she worked. Telephone interview with the House Manager at					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		FCL032096	B. WING			1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	JONES FAMILY HOME 2122 OVI			VE .		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		NCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		.D BE	(X5) COMPLETE DATE
{C 131}	Continued From pa	ge 12	{C 131}			
	-Staff A had compleincluding the 15-ho clinical skills checkleshe could not find training paperwork.	a copy of Staff A's medication v with the Director on 01/29/25				
	-Staff A had comple -He would have the facility send a copy training.	eted all required MA training. House Manager at the sister of Staff A's completed MA				
	Requests for Staff A's medication aide training on 01/28/25 and 01/29/25 were not provided by the survey exit date.					
	Based on interview was unable to be in	s it was determined Staff A Iterviewed.				
		ne interview with the 1/30/25 at 2:57pm was				
{C 145}	10A NCAC 13G .04 Qualifications	106(a)(5) Other Staff	{C 145}			
	(a) Each staff pers shall:(5) have no finding	106 Other Staff Qualifications on of a family care home as listed on the North Carolina nnel Registry according to G.S.				
		et as evidenced by: views and interviews, the ure that 1 of 3 sampled staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 t. BOILBING.		F	₹
		FCL032096	B. WING		01/31/2025	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 145}	Continued From page 13		{C 145}			
	(A) had no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR).					
	The findings are:					
	Review of Staff A's personnel record revealed: -There was no signed job description or hire dateThere was no documentation of a completed HCPR check.					
	Telephone interview with the House Manager at the sister facility on 01/29/25 at 1:21pm revealed: -Staff A worked at multiple sister facilitiesStaff A had a HCPR check completed upon hireShe could not find a copy of Staff A's HCPR check.					
	Telephone interview with the Director on 01/29/25 at 1:35pm revealed: -Staff A had a HCPR check completedHe would have the House Manager at the sister facility send a copy of Staff A's completed HCPR check.					
		A's HCPR check results on 1/25 were not provided by the				
	Based on interviews was unable to be in	s it was determined Staff A terviewed.				
		ne interview with the /30/25 at 2:57pm was				
{C 147}	10A NCAC 13G .04 Qualifications	06(a)(7) Other Staff	{C 147}			
	10A NCAC 13G .04	06 Other Staff Qualifications				

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 ti Boilebiirto.		R	
		FCL032096	B. WING		1	1/2025
NAME OF P	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	JONES FAMILY HOME 2122 OVE DURHAM			VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	JLD BE	(X5) COMPLETE DATE
	shall: (7) have a criminal in accordance with available in the staff. This Rule is not me Based on record refacility failed to ensity (A) had a criminal bupon hire. The findings are: Review of Staff A's -There was no sign -There was no doct background check. Telephone interview the sister facility on -Staff A worked at n -Staff A had a background check. Telephone interview at 1:35pm revealed -A background check. Telephone interview at 1:35pm revealed -A background check. Requests for Staff A. -He would have the facility send a copy background check. Requests for Staff A check on 01/28/25 provided by the sur	on of a family care home background check completed G.S. 131D-40 and results f person's personnel file; et as evidenced by: views and interviews, the ure that 1 or 3 sampled staff background check completed personnel record revealed: ed job description or hire date. umentation of a criminal w with the House Manager at 01/29/25 at 1:21pm revealed: nultiple sister facilities. ground check completed. a copy of Staff A's w with the Director on 01/29/25 ck had been competed on House Manager at the sister of Staff A's completed A's completed background and 01/29/25 were not	{C 147}			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,	0. 0020		A. BUILDING:			
		FCL032096	B. WING		R 01/31/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IONES FAMILY HOME			RLAND DRI , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETI	
{C 147}	Continued From page 15		{C 147}			
	Attempted telephone interview with the Administrator on 01/30/25 at 2:57pm was unsuccessful.					
{C 148}	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications		{C 148}			
	10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file;					
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 3 of 3 sampled staff (A, B, and C) had an examination and screening for the presence of controlled substances completed upon hire.					
	The findings are:					
	-There was no sign -There was no docu	n's personnel record revealed: ed job description or hire date. Lumentation Staff A had an Ereening for the presence of Ees available.				
	the sister facility on -Staff A worked at n -Staff A had a drug	w with the House Manager at 01/29/25 at 1:21pm revealed: nultiple sister facilities. screen completed upon hire. a copy of Staff A's drug				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				 	R		
	FCL032096		B. WING		01/3	1/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
JONES F	AMILY HOME		RLAND DRI	VE			
			NC 27704	PROVIDERIO DI AMI OF GORDECTI	211		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE	
{C 148}	Continued From pa	ge 16	{C 148}				
	at 1:35pm revealed -He was responsibl personnel records of -Staff A had a drug was hiredHe would have the facility send a copy Requests for Staff A 01/28/25 and 01/29 survey exit date. Based on interview was unable to be in Attempted telephon Administrator on 01 unsuccessful. 2. Review of Staff E -Staff B was hired a 01/03/21There was no docu examination and so controlled substance Telephone interview 3:50pm revealed he 01/25/25; he would Telephone interview the sister facility on -Staff B worked at s -Staff B "just" had a -She could not find screen	e for making sure the were complete. screen complete. screen completed when she e House Manager at the sister of Staff A's drug screen. A's drug screen results on 1/25 were not provided by the sit was determined Staff A terviewed. The interview with the 1/30/25 at 2:57pm was B's personnel record revealed: as the House Manager on the presence of the sea available. We with Staff B on 01/28/25 at the had a drug screen on get a copy of the results. We with the House Manager at 01/29/25 at 1:21pm revealed: sister facilities too.					

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DIVISION	<u>of Health Service Re</u>	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL032096	B. WING		R 01/31/2025	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRIV , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 148}	Continued From pa	ge 17	{C 148}			
	personnel records of Staff B had a drug an older drug scree tooHe would have the facility send a copy Requests for Staff B 01/28/25 and 01/29 survey exit date. Attempted telephon Administrator on 01 unsuccessful. 3. Review of Staff C -Staff C was hired a (SIC) on 07/08/96	e for making sure the were complete. screen recently and there was n in Staff B's personnel record House Manager at the sister of Staff B's drug screen. B's drug screen results on /25 were not provided by the				
		reening for the presence of				
	revealed: -He had a drug scremonths agoHe did not have a	C on 01/18/25 at 3:38pm een at the sister facility about 3 copy of the results, but he Manager for the sister facility				
	the sister facility on -Staff C worked for facilities for a long t -Staff C had a drug ago.	with the House Manager at 01/29/25 at 1:21pm revealed: the facility and/or sister ime. screen a couple of months				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
		FCL032096	B. WING		01/3	₹ 1/ 2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI , NC 27704	VE		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5) COMPLETE DATE	
{C 148}	Continued From pa	ge 18	{C 148}			
	at 1:35pm revealed -He was responsible personnel records v -Staff C had a drug -He would have the facility send a copy Requests for Staff (01/28/25 and 01/29 survey exit date. Attempted telephone	e for making sure the were complete. screen "not long ago." House Manager at the sister of Staff C's drug screen. C's drug screen results on /25 were not provided by the				
{C 185}	unsuccessful.	/30/25 at 2:57pm was 01(a) Management and Other	{C 185}			
(0 .00)	Staff	or(a) Management and Other	(5 .55)			
	10A NCAC 13G .06 Staff	01 Mangement and Other				
	approved in accordance Subchapter shall be operation and manal assure that all care maintain the health, residents in accordance state, and federal readministrator shall a Division of Health Scounty department complying with the co-administrator, where the subchapter of the face of the subchapter of	ome administrator who is ance with Rule .1501 of this e responsible for the total agement of the facility to and services are provided to a safety, and welfare of the ance with all applicable local, egulations and codes. The also be responsible to the service Regulation and the of social services for rules of this Subchapter. The then there is one, shall share with the administrator for the service of this Subchapter. The of this Subchapter. The service of this Subchapter. The of this Subchapter. The				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		FCL032096	B. WING		I	31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES I	JONES FAMILY HOME 2122 OV DURHAM			VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{C 185}	Continued From parterm "administrator co-administrator who Subchapter.	" also refers to nere it is used in this	{C 185}			
	Based on these find Violation was not all Based on observation interviews, the Admoverall management procedures of the find maintained in substrules and statutes the adult care homes refurnishings, and metallocated in the statutes of the finding of the statutes of the s	YPE B VIOLATION dings, the previous Type B				
	Observation of the 8:05am-5:50pm rev Supervisor-in-Charmember at the facil Interview with five r 8:12am-9:56am rev-One resident though AdministratorFour residents the Owner/Administrator.	ge (SIC) was the only staff lity. esidents on 01/28/25 from realed: ght the [named] SIC was the light the Director was the				

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	NT OF DEFICIENCIES		(Y2) MI II TIDI	E CONSTRUCTION	(X3) DATE	QLID\/EV
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			LETED
			A. DUILDING.			
		ECI 032006	B. WING		F 04/2	
		FCL032096	L		1 01/3	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI	VE		
DURHAM		, NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 185}	Continued From page 20		{C 185}			
	[named] Administrator wasIf they needed anything, they asked whoever was working.					
	Interview with the SIC on 01/28/25 revealed: -He had only been at the facility working since 01/20/25If he needed anything, he called the Director or					
	the House Manager.					
	Telephone interview with the Director on 01/29/25 at 1:33pm revealed: -The Administrator was at the facility once a					
	monthHe was at the facility with the Administrator in November 2024 and December 2024The Administrator looked at some records and asked how the residents were doing.					
	Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -She was last at the facility in December 2024She had not been to the facility in January 2025 because of a family member's healthIn December 2024, she went to the facility twiceShe did not work on anything else while at the					
	after ThanksgivingShe was trying to f did in November 20 -She was going to h often because she	cility once in November 2024, ind her notes to see what she 24. have to go to the facility more thought the Director was going asure they were implemented.				
		as identified in the following				
		ations and interviews, the naintained in a clean and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL032096	B. WING		R 01/31/2025	
	PROVIDER OR SUPPLIER	2122 OVE	DRESS, CITY, S' RLAND DRIV , NC 27704	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 185}	live and dead bed bedroom and live a the dining room. [Ref 13G .0315(a)(5) Ho (Type B Violation)]. 2. Based on observer reviews, the facility medications as orderesidents (#1, #2, a and toothpaste (#1) after chemotherapy [Refer to Tag 330, 1] Medication Adminis 3. Based on record facility failed to ensure of 3 sampled reside ophthalmologist appappointment, and lareviews and interviews and interviews and residents (#1) relate appointment, a den work. [Refer to Tag Health Care(Type E) 4. Based on observer views, the facility as ordered for 1 of had an order for a reto Tag 284, 10A NC and Food Service (5. Based on intervieg facility failed to ensure the distribution of the control of the	d free of hazards, related to bugs observed in a resident's and dead roaches observed in a fer to Tag 078, 10A NCAC busekeeping and Furnishings ations, interviews, and record failed to administer and failed to administer at a steroid medication used and #3) related to eye drops a steroid medication used at (#2), and a steroid (#3). IOA NCAC 13G .1004(a) attration (Type B Violation)]. The reviews and interviews, the cure referral and follow up for 1 and sointment, a dentist ab work. Based on record at a work and interviews, the facility failed to follow up for 1 of 3 sampled and to an ophthalmologist appointment, and lab 246, 10A NCAC 13G .0902(b) a Violation)]. ations, interviews, and record failed to serve supplements 1 sampled resident (#2) who nutritional supplement. [Refer AC 13G .0904(e)(4) Nutrition	{C 185}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:						B) DATE SURVEY COMPLETED	
			71. 501251110.			₹	
		FCL032096	B. WING			1/2025	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
JONES F	JONES FAMILY HOME 2122 OV DURHAM			VE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{C 185}	Continued From pa	ge 22	{C 185}				
	15-hour medication aide (MA) training course or had verification she had previously worked as a MA before administering medication to residents. [Refer to Tag 131 10A NCAC 13G .0403(a) Other Staff Qualifications].						
	facility failed to ensi (A, B, and C) had a for the presence of	ews and record reviews, the ure that 3 of 3 sampled staff in examination and screening controlled substances e. [Refer to Tag 148 10A 1)(8) Other Staff					
	7. Based on record reviews and interviews, the facility failed to ensure that 1 of 3 sampled staff (A) had no substantial findings listed on the North Carolina Health Care Personnel Registry (HCPR). [Refer to Tag 145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications].						
	facility failed to ensu (A) had a criminal b	reviews and interviews, the ure that 1 or 3 sampled staff packground check completed Tag 147 10A NCAC 13G staff Qualifications].					
	facility failed to implor of 3 sampled reside	ews, and record reviews, the lement physician's orders for 2 ents (#1 and #2) with orders [Refer to Tag 249, 10A NCAC Health Care].					
	record reviews, the four fire drills were	rvations, interviews, and facility failed to ensure at least held annually. [Refer to TAG G .0316(e) Fire Safety and					
	11. Based on obser	vations, interviews, and record					

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PRINTED: 02/17/2025 FORM APPROVED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
		FCL032096	B. WING			1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI	VE .		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	NC 27704	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
{C 185}	Continued From pa	ge 23	{C 185}			
{C 103}	reviews, the facility medication administ for 2 of 3 sampled in medication used to antifungal cream (# (#3). [Refer to TAG Medication Administ 12. Based on observiews, the facility readily retrievable in substances by doct administration, and resident (#1) with a to treat anxiety. [Refore 13G .1008(a) Control The Administrator for management, operafacility were implemedications were a resident whose medaily when the medication administration was a resident whose medaily when the medication administration was a resident whose medaily when the medication administration and the facility was a resident whose medaily when the medication administration and the facility was a resident whose medications was a resident whose medications was a resident whose medication administration and the facility was a resident whose medication administration and the facility was a resident whose medications was a resident whose medi	failed to ensure the stration records were accurate residents (#1, #3) including a treat constipation and an treat constitution and treat to the stration and policies of the treat to a dication was administered lication should have only been	{C 100}			
	administered for 2 days following chemotherapy (#2) and a resident's fluoride toothpaste and eye drops to lower the pressure in his eyes was not administered as ordered, and the resident had not been to his follow-up eye doctor or dentist appointment or labs obtained (#1); and a resident who had a significant weight loss and his nutritional supplement was not administered as ordered (#2). The Administrator's failure was					
	detrimental to the h the residents, which Type B Violation.	d a plan of protection in S. 131D-34 on 02/17/25.				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		FCL032096	B. WING			1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	JONES FAMILY HOME 2122 OVE DURHAM			VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 24	C 246			
C 246	10A NCAC 13G .09	002(b) Health Care	C 246			
	10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.					
	This Rule is not met as evidenced by: TYPE B VIOLATION					
	Based on record reviews and interviews, the facility failed to ensure referral and follow up for 1 of 3 sampled residents (#1) related to an ophthalmologist appointment, a dentist appointment, and lab work.					
	The findings are:					
	Review of Resident #1's current FL-2 dated 05/03/24 revealed diagnoses included hypertension, osteoarthritis, Parkinson's disease, anemia, gastroesophageal reflux disease, sleep apnea, chronic obstructive pulmonary disease, vitamin D deficiency, gingivitis, and chronic paranoid schizophrenia.					
	1:04pm revealed: -He had not had his -He could not "see -His vision was gett -His vision was blur	ing "worse and worse."				
	Ophthalmologist's a 3:03pm revealed: -Dorzolamide-timol	w with Resident #1's assistant on 01/28/25 at ol (a combination eye drop treat glaucoma, a condition				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL032096	B. WING		01/3	R 1/ 2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	FAMILY HOME		RLAND DRIV , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 25	C 246			
	damage vision) was #1's glaucomaResident #1 was la 02/07/24On 02/07/24, Resident his right eye and -Resident #1 was to his eye pressure chewhen the resident been told to schedu 6 monthsA follow-up appoint Resident #1A request for a refident borzolamide-timolomedication used to that increases president was sent to the facility's confological to the facility of the facility	o return to the office to have necked in 6 months. left the office, he would have alle a follow-up appointment in the theorem and for the resident's of (a combination eye drop treat glaucoma, a condition sure in the eye and can be requested on 07/05/24 and lity's contracted pharmacy. What with a pharmacy technician contracted pharmacy on montracted pharmacy on mo				

with the pharmacist, and observation of

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			71. 501251110.		R	
		FCL032096	B. WING		01/3	1/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES	JONES FAMILY HOME 2122 OV DURHAM			VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 246	medications on har not receive his eye Review of an Ameri Ophthalmology door revealed each pers different, and there pressure for everyonormal pressure was (mmHg means "mi used to record eye Telephone interview 01/28/25 at 3:50pm-He took Resident ago" to get glasses -He did not know w Resident #1 saw, be eyeglasses. He thought the app was 6-7 months agone He took Resident #1 saw, be eyeglasses. He took Resident #1 office to check his possible to check his possible to check his possible to check his possible to check ed. If he was suppose appointment, he may scheduling it. Telephone interview care provider (PCP revealed: She saw Resident -She recalled	ad, revealed Resident #1 did drops as ordered. Ican Academy of sument dated 04/12/22 on's eye pressure was was no single correct one. Generally, the range for as between 10 and 21 mmHg illimeters of mercury," a scale pressure). If with the House Manager on revealed: If to the eye doctor, "not long that kind of eye doctor ut it was a full eye exam for cointment with the eye doctor on. If to the same eye doctor's	C 246			

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL032096	B. WING		01/3	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TO WILL OF T	TO VIBER OR GOLF EIER		RLAND DRI	,		
JONES F	FAMILY HOME		, NC 27704	V L		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE
C 246	Continued From page 27		C 246			
	-It was very important for Resident #1 to see his Ophthalmologist to check his eye pressure.					
	Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed she was not aware Resident #1 had missed an eye appointment.					
		ne interview with Resident #1's 01/28/25 at 3:03pm was				
	Refer to the intervie Supervisor-in-Charg 3:38pm.	ew with the ge (SIC) on 01/18/25 at				
	Refer to the telepho Manager on 01/28/2	one interview with the House 25 at 3:50pm.				
	Refer to the telepho on 01/29/25 at 10:3	one interview with the Director 2am.				
	Refer to the telepho Administrator on 01	one interview with the /29/25 at 12:24pm.				
	summary dated 11/ revealed:	ent #1's PCP's after-visit 05/24, 12/10/24, and 01/17/25				
	-Resident #1 was s management. -Please take for lab	een for chronic care s.				
		dent #1 on 01/28/25 at 1:04pm recall having any bloodwork e."				
	01/29/25 at 11:59ar -She ordered labs f	wwith Resident #1's PCP on m revealed: or Resident #1 because the d lab work in over a year.				

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-She reminded the staff member every month

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	, l
			B. WING		R	
		FCL032096	B. WING		01/3	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			RLAND DRI			
JONES F	AMILY HOME		, NC 27704	V E		
			, 140 27704			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		DATE
17.0		,	17.0	DEFICIENCY)		
C 246	Continued From pa	ge 28	C 246			
	Resident #1's lab w	ork needed to be done.				
	Troolagine // To lab 11	on necuca to 20 dene.				
	Telephone interview	v with Resident #1's PCP on				
	01/30/25 at 9:53am					
		work was ordered to monitor				
	the resident's overa					
		ensure medications were				
	effective.	Chould inculations were				
		n albumin level (used to see if				
	-She had ordered an albumin level (used to see if the body was absorbing enough protein) for					
	Resident #1.	bing chadgir protein, for				
		ke sure Resident #1's kidney				
	function was okay.	Re sale resident #13 kidney				
		ke sure Resident #1's				
	complete blood cou					
		hite blood count were all within				
	normal range.	The blood count were all within				
	normai range.					
	Telephone interview	v with the House Manager on				
	01/29/25 at 9:44am					
		#1 had an order for lab work.				
		he paperwork for him to take				
		lab to get blood work done.				
		to get Resident #1 to go, but				
		say he did not want to go when				
	he asked.	say he did not want to go when				
		etting older and did not like to				
	leave the facility.	our golder and did not like to				
		e was going to take Resident				
	#1 to get the lab wo					
		he had told the PCP Resident				
	#1 had refused to g					
	,,	,				
	Telephone interview	w with the Director on 01/29/25				
	at 10:32am reveale					
		er was responsible for making				
		lab work was obtained.				
		roblems getting Resident #1's				
	labs, he should hav					
		Resident #1 had refused to go				
	i ic was flot awale	TOSIGOTIC # 1 Had TOTUSED TO 90				

STATE FORM 6899 QYIW12 If continuation sheet 29 of 77

	IT OF DEFICIENCIES		(VO) MULTIPL	E CONCEDUCTION	(V2) DATE	CLIDVEV
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	LETED
			A. BUILDING:			
			D MINO		F	
		FCL032096	B. WING		01/3	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IONEO		2122 OVE	RLAND DRI	VE		
JONES I	FAMILY HOME	DURHAM	, NC 27704			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
1710		,	1710	DEFICIENCY)		
C 246	Continued From pa	ge 29	C 246			
	to the lab.	g				
	to trie lab.					
	Refer to the intervie 3:38pm.	w with the SIC on 01/18/25 at				
	Refer to the telephone interview with the House Manager on 01/28/25 at 3:50pm.					
	Refer to the telephone interview with the Director on 01/29/25 at 10:32am.					
	Refer to the telephone interview with the Administrator on 01/29/25 at 12:24pm.					
	c. Interview with Resident #1 on 01/28/25 at 1:04pm revealed and 5:08pm revealed: -His teeth were "okay" for nowHe could not recall the last time he went to the dentist, but it had been a long time, more than a year.					
	01/28/25 at 3:31pm -He was concerned seen by a dentist siruments in 202 -Cleaning was imported the residuental careThe resident could gingivitis (an inflamithe accumulation of bacteria that builds oral hygiene)The resident needefor routine dental careHe ordered Previde Resident #1 because	Resident #2 had not been nce 2022. e "no-shows" and rescheduled 22, 2023, and 2024. ortant in oral care and he was lent had not been seen for have some issues with mation of the gums caused by plaque, a sticky film of up on the teeth, from poor ed to be seen every 6 months				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. Bolesine.		R	
		FCL032096	B. WING			1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	JONES FAMILY HOME 2122 OVI			VE		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
C 246	Continued From pa	ge 30	C 246			
	in preventing addition	onal cavities.				
	Observation of Resident #1's medications on hand on 01/28/25 at 9:30am revealed there was no Prevident 5000 toothpaste available to be administered.					
	Telephone interviews with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am and 2:24pm revealed: -Prevident 5000 toothpaste was used for fluoride which could help prevent cavitiesResident #1's Prevident toothpaste was filled on 07/23/24 and 08/18/24 for a 30-day supply for each dispensingResident #2's Prevident toothpaste was refilled on 01/27/25 and would be delivered to the facility on 01/29/25.					
	Based on review of medication orders, interview with the pharmacist, and observation of medications on hand, revealed Resident #1 did not receive his Prevident 5000 toothpaste as ordered.					
	01/28/25 at 3:50pm -He drove to Reside one week ago to m Resident #1, but the -He did not know are appointments in 20 the House Manage	ent #1's dentist's office about ake an appointment for e dentist's office was closed. hything about missed 22 because he had only been r for "about" two years. ot had any complaints or				
	01/28/25 at 4:16pm -Resident #1's teetl	w with Resident #1's PCP on revealed: n were not in the best eeded to be seen by a dentist.				

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Division	<u>of Health Service Re</u>	gulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74401 1544	OF CONTRECTION	BENTH IOATION NOMBER.	A. BUILDING:			
		FCL032096	B. WING		R 01/31/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES FAMILY HOME		RLAND DRIV , NC 27704	VE			
	0.0000000000000000000000000000000000000		-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 31	C 246			
	-She was not aware Resident #1 had not been seen by the dentist.					
	at 10:32am reveale -He was with the Ho they went by Resido was closed.	ouse Manager recently when ent #1's dentist's office, and it oppointment was made for				
	01/29/25 at 12:24pr -She was told the S dentist office 3 time returned his call; tw -If the dentist did no	IC had called Resident #1's s and the dentist had not				
	Refer to the intervieus:3:38pm.	ew with the SIC on 01/18/25 at				
	Refer to the telepho Manager on 01/28/2	one interview with the House 25 at 3:50pm.				
	Refer to the telepho on 01/29/25 at 10:3	one interview with the Director 2am.				
	Refer to the telepho Administrator on 01	one interview with the //29/25 at 12:24pm.				
	revealed he did not	IC on 01/18/25 at 3:38pm have anything to do with nts, because that was the esponsibility.				
	Telenhone interview	with the House Manager on				

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01/28/25 at 3:50pm revealed:

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		FCL032096	B. WING		01/3	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IONES E	EAMILY HOME	2122 OVE	RLAND DRI	VE		
JONES FAMILY HOME DURHAM,			NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 32	C 246			
	-He was responsible activity of the facility of the facility -He took residents scheduled appoint of the occasionally we but it was usually of the touse managers at 10:32am reveale -The House Managers all follow-to-The House Managers and the residents to the -He was concerned.	e for overseeing the normal y. to appointments, and he nents. Orked as the SIC at the facility, nly for a few hours. If with the Director on 01/29/25 d: the responsible for up appointments were made, ler was responsible for taking ir appointments. If appointments had been to be putting systems in place to				
	Telephone interview 01/29/25 at 12:24pr -The Director was r appointments were to the appointments -She did not know t appointmentsThe Director was r making sure they we she expected the setter than they we needed. The facility failed to for a resident (#1) v Ophthalmologist to checked in over six his eye drops used resident had a diag been seen by a der used the fluoride to ordered for prevent	w with the Administrator on m revealed: esponsible for making sure made and the residents went s. the residents were missing not going over the orders and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. BOILDING.		R	
		FCL032096	B. WING			1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES FAMILY HOME			RLAND DRI , NC 27704	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 33	C 246			
	not had any bloodw was detrimental to of the residents and Violation.	all health and the resident had york completed. This failure the health, safety and welfare d constitutes a Type B				
		d a plan of protection in S. 131D-34 on 01/31/25 for				
		N DATE FOR THIS TYPE B NOT EXCEED MARCH 17,				
C 249	10A NCAC 13G .09	002(c)(3)(4) Health Care	C 249			
	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.					
	facility failed to imp	et as evidenced by: s, and record reviews, the lement physician's orders for 2 ents (#1 and #2) with orders				
	The findings are:					
	revealed diagnoses emphysema, hyper	ent #2's FL-2 dated 11/01/23 included pulmonary tension, schizophrenia, izophrenia, and legally blind in				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. Boilbing.		R	
		FCL032096	B. WING			1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI' , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 249	Continued From pa	ge 34	C 249			
	the left eye.					
	Review of Resident (PCP) after-visit surrevealed Resident and Review of Resident and Review of Resident and Resident #2 weighters and Resident #2 had at a There was an order notify the PCP for a lbs. Review of Resident summaries reveale -On 09/06/24, Resident loss. -On 10/06/24, Resident New 10/10/24, Resident 10/10/24, Resident New 10/10/2	ed 152.8 lbs. 13 lb weight loss. er to weigh weekly, record, and a weight change greater than 5 ##2's PCP after-visit d: ident #2 weighed 149 lbs; a 3 dent #2 weighed 147 lbs. dent #2 weighed 145.2 lbs. dent #2 weighed 146.6 lbs. ##2's November 2024, and January 2025 from				
	01/01/25-01/28/25 records (MAR) reve	medication administration ealed:				
	-There was an entr	y for monthly weights. ights documented on the front				
	revealed:	dent #2 on 01/28/25 at 1:25pm				
	facility.	when the doctor was at the ed weekly by staff at the				
	facilityHe had lost "quite"					
		v with the House Manager on revealed he did not know				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		FCL032096	B. WING			1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI NC 27704	VE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 249	Continued From pa	ge 35	C 249			
	Resident #2 had an	order for weekly weights.				
	Telephone interview 01/28/25 at 4:16pm -Resident #2 had w the resident be weigmonitor any ongoin -She was concerne ongoing weight loss notifiedShe expected staff Refer to the intervie Supervisor-in-Chargan. Refer to the telephomanager on 01/28/2000 Refer to the telephomanager on 01/29/2000 Refer to the telephomanager on 01/2000 Refer to the telephomanager to the telephomanager on 01/2000 Refer to the	w with Resident #2's PCP on revealed: reight loss and she requested ghed weekly so she could g weight loss. d that the resident could have s, and she had not been f to follow the order as written. w with the ge (SIC) on 01/28/25 at one interview with the House 25 at 3:50pm. one interview with the House 25 at 9:44am. one interview with the Director				
		one interview with the				
	05/03/24 revealed of hypertension, osteo gastroesophageal richronic obstructive deficiency, gingivitis schizophrenia.	parthritis, Parkinson's, anemia, reflux disease, sleep apnea, pulmonary disease, vitamin D s, and chronic paranoid				
	(PCP) after-visit su	:#1's primary care provider's mmary dated 12/10/24 #1 weighed 160.4 pounds				

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(lbs.).

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STATE FORM

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			7 ti Bolebiiro.			٦
		FCL032096	B. WING		I	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI' , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
C 249	Continued From pa	age 36	C 249			
	dated 01/17/25 revi- Resident #1 weight- Resident #1 had a -There was an order weekly, record, and change greater that Review of Resident medication administration.	ned 155 lbs. If 5 lb weight loss. If to weigh Resident #1 If notify the PCP for a weight in 3 lbs. If #1's January 2025 It #1's from				
	01/01/25-01/28/25 -There was an entr -There were no we or back of the MAR	y for monthly weights. ights documented on the front				
	revealed:	dent #1 on 01/28/25 at 1:25pm when the doctor was at the				
	-He was not weight facility.	ed weekly by staff at the he had lost any weight or not.				
	01/28/25 at 3:50pm	w with the House Manager on n revealed he did not know n order for weekly weights.				
	01/28/25 at 4:16pm -Resident #1 had we the resident be weimonitor any ongoin -She was concerned ongoing weight loss -She expected staff	veight loss and she requested ghed weekly so she could be weight loss. Be that the resident could have so to follow the order as written.				
	Refer to the intervie Supervisor-in-Char 11:28am.	ew with the ge (SIC) on 01/28/25 at				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING.			₹
		FCL032096	B. WING		1	31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES I	FAMILY HOME		ERLAND DRI' , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODERICENCY)	JLD BE	(X5) COMPLETE DATE
C 249	Continued From pa	nge 37	C 249			
	Refer to the telepho Manager on 01/28/	one interview with the House 25 at 3:50pm.				
	Refer to the telepho Manager on 01/29/	one interview with the House 25 at 9:44am.				
	Refer to the telepho on 01/29/25 at 10:3	one interview with the Director 32am.				
		one interview with the 1/29/25 at 12:24pm.				
	revealed:	SIC on 01/28/25 at 11:28am umented on the back of the				
	started working at t -The facility did not -The facility's contra	ed any residents since he the facility on 01/20/25. have scales that worked. acted PCP weighed the				
	weightsAll the residents ha	er monthly visits. ents had an order for weekly ad an order for monthly				
	weights.					
	01/28/25 at 3:50pm	w with the House Manager on revealed: d not do weekly or monthly				
	weights.	weighed the residents every				
	01/29/25 at 9:44am -Whoever was wor PCP made her moi	king at the facility when the nthly visits was responsible for and making sure any orders				

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DIVISION	of Health Service Re	guiation	1		,	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		` '		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						,
		FCL032096	B. WING		R 01/31/2025	
		FOLU32090			1 01/3	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		2122 OVE	RLAND DRI	VE		
JONES F	AMILY HOME	DURHAM.	NC 27704			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(Y5)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
C 249	Continued From pa	ge 38	C 249			
	·					
		oing behind the staff to make				
		doing what they were				
	supposed to do.					
	-	''I II B'				
		with the Director on 01/29/25				
	at 10:32am reveale					
		ere were orders for weekly				
	weights.	ave called him if the facility				
	-The staff should have called him if the facility needed scales.					
		working the day the DCD wrete				
		working the day the PCP wrote ave written the order on the				
	MAR for weekly we					
		er should go behind the SIC				
		er should go berillid the SiC ers were implemented.				
	and make suite orde	ers were implemented.				
	Telephone interview	with the Administrator on				
	01/29/25 at 12:24pr					
		onsible for following all new				
	orders.	orisible for following all flew				
		esponsible for making sure all				
	new orders had bee					
		he residents had orders for				
		were not being done.				
		d the residents were not				
	weighed as ordered					
		SIC to read over the orders				
	thoroughly.	_				
		esponsible for making sure				
		es to do the weekly weights.				ļ
	·					ļ
C 257	10A NCAC 13G 09	04(a)(1) Nutrition and Food	C 257			ļ
	Service	- ()() /				
						ļ
	10A NCAC 13G .09	04 Nutrition and Food Service				ļ
		ent and Safety in Family Care				ļ
	Homes:	•				
		hall comply with Rules				ļ
	Governing the Sani	tation of Residential Care				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
					R	
		FCL032096	B. WING		1	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI	VE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
C 257	Continued From pa Facilities set forth in	ge 39 n 15A NCAC 18A .1600 which	C 257			
	are hereby incorpor subsequent amend preparation, and se conditions. This Rule is not me Based on observati interviews, the facili	rated by reference, including ments, assuring storage, erving food under sanitary et as evidenced by: ons, record review and ity failed to ensure all food				
	to observations of r	ed from contamination related oaches, both living and dead, oters and dead roaches in the				
	The findings are:					
	Inspection report da -There were 9 total -Demerits included repair, walls, ceiling repair, handwashing presenceTwo live roaches wand dead roaches win the kitchen as we	floors and carpet in good ys, and attachments in good g provided, and pest were observed in the kitchen were observed in the cabinets				
	facilityBe sure to remove	dead pests to prevent				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		FCL032096	B. WING		01/3	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 257	Continued From pa	ge 40	C 257			
	harborage.					
	revealed: -There was a live counterThere were 2 live the kitchen counter	kitchen on 01/28/25 at 8:33am ockroach on the kitchen roaches on the wall between and the wall cabinets.				
	8:34am revealed: -There were multiple refrigerator.	refrigerator on 01/28/25 at le dead roaches in the cockroach on the door gasket.				
	01/28/25 at 3:26pm -He had seen roach -He had not told the					
	the facility's contract 01/18/25 at 12:44pt - The facility had no their company The facility had no - The facility could be	w with a representative from sted pest control company on m revealed: t been treated for roaches by t requested pest treatment. The treated for roaches, but the request pest treatment.				
	8:25am revealed: -She saw live and control of the saw live and control of the saw live and control of the saw live roaches eat desired the saw live roaches eat desired of the saw live and control of the saw live an	Ith Specialist on 01/29/25 at dead roaches at the facility on iseases. ded to be cleaned up because				

Division of Health Service Regulation

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
						R	
		FCL032096	B. WING		01/3	1/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
JONES F	FAMILY HOME		RLAND DRI' , NC 27704	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 257	the locations and colive, thrive, and reproved a final been roaches. He had seen roaches would ke cleaned up. Telephone interview 01/29/25 at 9:44am - He had seen roaches. He had seen roaches at final been finamed] spray that residents. He could not make control company. The staff working to the staff had been roaches. He used a [named treat the roaches. He had not called the treat the roaches. He had not read the dated 01/06/25. Cleaning the facilitic clean up dead pest - If the SIC did not con 01/28/25, it was proceed to the clean up dead pest - If the SIC did not con 01/28/25, it was proceed to the clean up dead pest - If the SIC did not con 1/28/25, it was proceed to 1/28/25	control, harborage referred to conditions where pests could roduce). ep "coming around" if not w with the House Manager on revealed: nes at the facility, "now and treating the roaches using a was safe to use around the e the decision to use a pest usually sprayed at night. w with the Director on 01/29/25 d: treating the facility for safe spray once a month to ay was working because the bad' but were getting better. The pest control company to the entire the pest control company to the safe spray oncess to	C 257				
	primary care provid 11:59am revealed:	with the facility's contracted er (PCP) on 01/29/25 at roaches at the facility.					

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					 	3
		FCL032096	B. WING		1	1/2025
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES F	FAMILY HOME		RLAND DRI , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 257	Continued From pa	ge 42	C 257			
	-She thought the fa professionally exter Telephone interview 01/29/25 at 12:24pi	minated. www.with the Administrator on revealed:				
	roaches.	notified her of the presence of ave let her know they had				
	01/30/25 at 9:57am	with the Administrator on revealed she expected the ad roaches daily, as often as				
	revealed: -He cleaned the factories and not done possible. He swept the facilities evening.	ge on 01/29/25 at 11:38am				
	O1/29/25 at 12:24pr -The Director needs come out and treat -The facility needed -She was concerne	ed to have a pest company				
	Protection Agency (10/28/24 revealed r may trigger an asth eggs, outer coverin surfaces contained	nited States Environmental (EPA) publication dated roaches and their droppings ma attack. Their feces, saliva, g, or cuticles left behind on substances that were				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		FCL032096	B. WING			R 31/2025
	PROVIDER OR SUPPLIER	2122 OVE	DRESS, CITY, S' RLAND DRIV , NC 27704	TATE, ZIP CODE /E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 257	and on the surface carried bacteria tha	ge 43 spiratory conditions. Within of their bodies, roaches t could cause salmonella, d streptococcus if deposited in	C 257			
C 284	Service 10A NCAC 13G .09 Service (e) Therapeutic Die (4) All therapeutic supplements and the	004(e)(4) Nutrition and Food 004 Nutrition and Food ets in Family Care Homes: diets, including nutritional nickened liquids, shall be by the resident's physician.	C 284			
	reviews, the facility as ordered for 1 of					
	Review of Resident revealed diagnoses emphysema, hyper hyperlipidemia, sch the left eye. Review of Resident (PCP) after-visit su	#2's FL-2 dated 11/01/23 included pulmonary tension, schizophrenia, izophrenia, and legally blind in #2's primary care provider's mmary dated 07/09/24 #2 weighed 165 pounds (lb).				
		#2's PCP after-visit summary				

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Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X31 PROVIDERS DENTIFICATION NUMBER: R. WING R.
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2122 OVERLAND DRIVE DURHAM, NC 27704 (X4) ID PREFIX TAG CANDIDATE CROSS-REFERENCE OF OTHER PROPORIATE TAG CONTINUED FREID REGULATORY OR LSC IDENTIFYING INFORMATION) C 284 C 286 C 286 C 286 C 287 C 288
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2122 OVERLAND DRIVE DURHAM, NC 27704 [X4) ID PREFIX TAG [EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS TO ATTAGS CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-COMPA
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2122 OVERLAND DRIVE DURHAM, NC 27704 [X4) ID PREFIX TAG [REGULATORY OR LSC IDENTIFYING INFORMATION] C 284 C 286 C 286 C 386 Review of Resident #2's PCP after-visit summary dated 09/06/24 revealed:Resident #2's PCP after-visit summaries revealed:Resident #2's PCP after-visit summary dated 09/06/24 revealed:Resident #2's PCP after
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2122 OVERLAND DRIVE DURHAM, NC 27704 (X4) ID. (X5) ID. SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 284 C 284 C Continued From page 44 dated 08/07/24 revealed: -Resident #2 weighed 152.8 lbsResident #2 had a 13 lb weight lossThere was an order to weigh weekly, record, and notify the PCP if greater than 5 lbsThere was an order for a nutritional supplement twice daily. Review of Resident #2's PCP after-visit summary dated 09/08/24 revealed: -Resident #2 weighed 149 lbs; a 3 lb weight lossA nutritional supplement was ordered and confirmed for delivery. Review of Resident #2's PCP after-visit summaries revealed: -On 10/06/24, Resident #2 weighed 145.2 lbsOn 12/10/24, Resident #2 weighed 145.6 lbs. Review of Resident #2's November 2024, December 2024, and January 2025 from 01/10/125-01/28/25 medication administration
DONES FAMILY HOME 2122 OVERLAND DRIVE DURHAM, NC 27704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES DURHAM, NC 27704 (EACH DEFICIENCY MUST BE PRECEIBED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE
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December 2024, and January 2025 from 01/01/25-01/28/25 medication administration
December 2024, and January 2025 from 01/01/25-01/28/25 medication administration
01/01/25-01/28/25 medication administration
records (MAR) revealed:
-There was no entry for a nutritional supplement.
-There was no documentation a nutritional
supplement had been administered.
Internitary with the Companies in Charge (CIC) on
Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 11:28am revealed:
-He thought three [named] residents were
supposed to be starting a nutritional supplement,
but he did not know which residents or how oftenHe had not served a nutritional supplement to
Resident #2.
-There were a couple of nutritional supplements
in the refrigerator, but he had not served any.
in the reingerator, but he had not served any.
Observation of the refrigerator on 01/18/25 at
11:30am revealed there were 3 bottles of a

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			,
		FCL032096	B. WING		01/3	31/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	FAMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
C 284	Continued From pa	ge 45	C 284			
	nutritional supplem refrigerator.	ent in the bottom drawer of the				
	from the facility's co 01/28/25 at 11:58ar not dispensed a nu	w with a pharmacy technician ontracted pharmacy on merevealed the pharmacy had tritional supplement for usually dispensed from a apany.				
	facility's contracted 5:11pm revealed if nutritional supplem- would have been el	w with a pharmacist from the pharmacy on 01/28/25 at Resident #2's order for a ent was received, the order ntered into the MAR so staff then the nutritional supplement sident.				
	medical supply con revealed: -Resident #2 had b supplement from thand September 202-Three cases of a [had been sent to th case contained 24 supplementsThey had not sent supplements to Rereimbursed for the -A staff member at	named] nutritional supplement le facility for Resident #2; each individually packaged any additional nutritional sident #2 due to not being cases already sent. the facility was notified that ional supplements would not				
	revealed:					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		FCL032096	B. WING		l l	R 31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES I	FAMILY HOME		RLAND DRIV NC 27704	/E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 284	Continued From pa	ge 46	C 284			
	Telephone interview 01/28/25 at 3:50pm -Resident #2 had as supplementHe did not recall the should be on the relif Resident #2's nut documented on the forgot to document. Telephone interview 01/28/25 at 4:16pm -She ordered a nutre Resident #2 because healthThe order was for nutritional supplemental supplementa	w with the House Manager on revealed: In order for a nutritional Ine order details, but the order sident's MAR. Itritional supplement was not in MAR, it was because the staff it. It with Resident #2's PCP on in revealed: In r				
	at 10:32am reveale -He thought Reside supplement twice a -He had given Resi supplement when h	nt #2 got a nutritional day. dent #2 a nutritional				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		FCL032096	B. WING		01/3	R 1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	FAMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 284	a nutritional suppler-Resident #2 knew nutritional supplem Telephone interview 01/29/25 at 12:24pr-Orders for a nutriti faxed to the pharmadocumented as adriff Resident #2's nudelivered, she experience why it was not delivered. The facility failed to nutritional supplemental to lose with the residents and continued to lose with Garaccordance with Garaccord	ment. he was supposed to get the ent and usually asked for it. v with the Administrator on m revealed: onal supplement should be acy, entered on the MAR, and	C 284			
{C 330}	Administration 10A NCAC 13G .10	004 Medication Administration	{C 330}			
	preparation and ad prescription and no by staff are in acco (1) orders by a licer	ome shall assure that the ministration of medications, n-prescription and treatments rdance with: nsed prescribing practitioner ed in the resident's record; and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BOILDING.		,	R	
		FCL032096	B. WING		1	31/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
JONES I	FAMILY HOME		ERLAND DRI I, NC 27704	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
{C 330}	O) Continued From page 48		{C 330}				
	(2) rules in this Section and the facility's policies and procedures.						
	This Rule is not me TYPE B VIOLATIO						
	Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, and #3) related to eye drops and toothpaste (#1), a steroid medication used after chemotherapy (#2), and a steroid (#3).						
	The findings are:						
	1. Review of Resident #2's FL-2 dated 11/01/23 revealed diagnoses included pulmonary emphysema, hypertension, schizophrenia, hyperlipidemia, schizophrenia, and legally blind in the left eye.						
	summary dated 11/ Dexamethasone (a inflammation) 4mg	ent #2's oncology after-visit 15/24 revealed an order for steroid used to treat take 2 tablets for 2 days trapy treatments; start taking					
	summaries reveale	t #2's oncology after visit d the resident received 1/21/24, 12/12/24, 01/02/25,					
	medication adminis 11/20/24-11/30/24 r -There was an entr take two tablets eve	t #2's November 2024 stration record (MAR) from revealed: y for Dexamethasone 4mg ery morning for two days after a scheduled administration					

Division of Health Service Regulation

STATE FORM 6899 QYIW12 If continuation sheet 49 of 77

Division of Health Service Regulation		1				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AIND FLAIN	OI COMMECTION	IDENTII IOATION NOIVIDEN.	A. BUILDING:	<u></u>	COMP	LLILU
					R	
		FCL032096	B. WING		01/3	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
			RLAND DRI	•		
JONES F	AMILY HOME		, NC 27704	· -		
(V4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION)N	(Y5)
(X4) ID PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				BEI IGIENG!		
{C 330}	Continued From page 49		{C 330}			
	time of 8:00am.					
	-There was documentation Dexamethasone was					
		0am on 11/21/24 and				
	11/22/24.					
	Review of Resident #2's December 2024 MAR revealed:					
	-There was an entry	y for Dexamethasone 4mg				
	take two tablets every morning for two days after					
		a scheduled administration				
	time of 8:00am.					
		entation Dexamethasone was 0am on 12/01/24-12/24/24 at				
	8:00am.	0a111 011 12/0 1/24-12/24/24 at				
	-The initials were m	arked out from				
		and 12/15/24-12/24/24 and				
	documented as an					
		als were for 12/13/24 and				
	12/14/24.					
		#2's January 2025 MAR from				
	01/01/25-01/28/25 i					
		y for Dexamethasone 4mg ery morning for two days after				
		a scheduled administration				
	time of 8:00am.					
		entation Dexamethasone was				
	administered at 8:0	0am on 01/01/25-01/27/25.				
		eption documented for				
		had been dropped on the floor				
	and was not admini	stered.				
	Observation of Res	ident #2 on 01/18/25 at				
	10:28am revealed:					
		ached the SIC and stated,				
		g with me; I must have gotten				
	my medication wron					
	-"My heart is racing nervous."	, and I feel antsy and				
	-Something is "not	riaht "				
	Comouning to Hotel	······································	1			

Division of Health Service Regulation

STATE FORM 6899 QYIW12 If continuation sheet 50 of 77

DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						₹
		FCL032096	B. WING		01/31/2025	
		1 01002000			1 01/0	1/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IONES E	:AMILY HOME	2122 OVE	RLAND DRI	VE		
JUNES	JONES FAMILY HOME DURHAL					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				22.10.2.10		
{C 330}	Continued From pa	ge 50	{C 330}			
	-The SIC told him to	o lie down for a little while to				
	see if he felt better.					
	Cocond observation	of Resident #2 on 01/18/25				
	at 11:17am reveale					
		e SIC, "I cannot lay down;				
	something is not right with me." -The SIC took the resident's blood pressure and					
	told the resident his BP was normal.					
	-The SIC told Resident #2 to try to lie down.					
	Observation of Res	ident #2's medication on hand				
	on 01/28/25 at 11:1	9am revealed :				
		ications were in a multidose				
	plastic packet.					
		kamethasone tablets in the				
	multidose plastic pa					
		card of Dexamethasone 4mg				
		o take two tablets every				
		after chemotherapy.				
		dispensed on 11/15/24; 18 ning on the punch card.				
	tablets were remail	ing on the punch card.				
	Based on MAR revi	ews, interviews, and				
		dication on hand, it could not				
	be determined whe	,				
		as administered. There were				
	18 tablets of Dexan	nethasone on the punch card				
		ave been 14 tablets remaining.				
	Interview with Design	dent #2 on 01/28/25 at 1:25nm				
	revealed:	dent #2 on 01/28/25 at 1:25pm				
		chemotherapy last Thursday,				
	01/23/25.	onomoniorapy last mursuay,				
	-He had four rounds	s of chemotherapy, and each				
	round was three we					
		ay, 01/28/25, he had never felt				
	like he did today.					
	-"I am all nervous, I	ike on the inside"; it was hard				

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to explain.

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DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		FCL032096	B. WING		01/3	₹ 1/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
IONES		2122 OVE	RLAND DRI	VE			
JUNES	FAMILY HOME	DURHAM	NC 27704				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
{C 330}	Continued From pa	ge 51	{C 330}				
	revealed: -He had administer. Dexamethasone even working at the facility of the did not know with the card, "everyyouthe gave one table because he did not had received cheminedication to get or left he had known with received chemothe administered 2 table number of days or downwhere the documented or administer Residen 01/28/25, because when he was adminimorning medication. The tablet he drop multidose packet. Observation on 01/2-Dexamethasone with packetThe SIC pointed to tablet he droppedThe tablet was idea (used to prevent he the card for Dexamethasone with the SIC showed the punch card for Dexamethasone with the sick showed the card fo	rery day since he started ty, 01/20/25. Then Resident #2's last ment was. Examethasone tablet from the day". The formulation of Dexamethasone every day know what day Resident #2 otherapy and did not want the fut of the resident's system. The formulation of Dexamethasone for the ered and then stopped. The formulation of Dexamethasone for the ered and then stopped. The formulation of the formulation of the ered and then stopped. The formulation of the formulation o					

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STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		FCL032096	B. WING			1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI , NC 27704	VE		
(X4) ID PREFIX	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	.D BE	(X5) COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DAIL
{C 330}	Continued From pa	ge 52	{C 330}			
	on the MAR that he	had dropped.				
	1:50pm revealed: -He did not adminis Dexamethasone to -He did not answer administered all of tablet he had dropp now he was saying Dexamethasone to Telephone interview facility's contracted 2:03pm revealed: -Dexamethasone w -If Resident #2's De administered more resident could expe	day, 01/28/25. why he stated earlier he had his medications except the led, which was an aspirin, but he did not give day. w with a pharmacist from the pharmacy on 01/28/25 at least a steroid medication. Examethasone was often than it was ordered, the erience increased				
	-If Resident #2 had Dexamethasone 7	ell as a fluid buildup. been administered days in a row, the resident ed nervousness and could feel				
	nurse on 01/28/25 a -Resident #2 should days after his chem -Taking the Dexamo would cause increal -It could also cause					
	O1/29/25 at 12:24pr -She had seen the Dexamethasone to 2 days after chemo	order for Resident #2's be administered 2 tablets for				

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DIVISION	Division of Health Service Regulation					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					R	
		FCL032096	B. WING		01/31/2025	
		FCL032036			01/31	12025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IONEO		2122 OVE	ERLAND DRI	VE		
JONES F	JONES FAMILY HOME DURHAN					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEI IOIEIVOT)		
{C 330}	Continued From pa	ge 53	{C 330}			
	MAR so the medica	ation was not administered				
	when it was not supposed to.					
	Pefer to the telepho	one interview with the House				
	Manager on 01/28/					
		one interview with the House				
	Manager on 01/29/	25 at 9:44am.				
	Refer to the telepho	one interview with the Director				
	on 01/29/25 at 10:3					
	Refer to the telepho Administrator on 01	one interview with the 1/29/25 at 12:24pm.				
	2. Review of Reside 05/03/24 revealed:	ent #1's current FL-2 dated				
		d hypertension, osteoarthritis,				
		e, anemia, gastroesophageal				
		p apnea, chronic obstructive				
		, vitamin D deficiency,				
	gingivitis, and chror	nic paranoid schizophrenia.				
	-There was docume	entation for medication to see				
	the medication adm	ninistration record (MAR).				
	a Paview of Poside	ent #1's May 2024 MAR				
		or Dorzolamide-timolol (a				
		op medication used to treat				
		ion that increases pressure in				
		mage vision) instill one drop in				
	each eye twice dail					
	, = 111100 man	,				
		#1's November 2024 MAR				
	revealed:	,				
		y for Dorzolamide-timolol instill				
		ye twice daily with a scheduled				
		of 8:00am and 8:00pm.				
		entation Dorzolamide-timolol				
		wice daily at 8:00am and				
	8:00pm from 11/01/	124-11/30/24.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		F	,
		FCL032096	B. WING			1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	FAMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ge 54	{C 330}			
	revealed: -There was an entrone drop in each eyadministration time -There was docume was administered to 8:00pm from 12/01 Review of Resident 01/01/25-01/28/25 -There was an entrone drop in each eyadministration time -There was docume was administered to 8:00pm from 01/01 Observation of Resident on 01/28/25 ano Dorzolamide-time	t #1's January 2025 MAR from revealed: y for Dorzolamide-timolol instill ye twice daily with a scheduled of 8:00am and 8:00pm. entation Dorzolamide-timolol wice daily at 8:00am and /25-01/28/25. sident #1's medications on the 9:30am revealed there was				
	from the facility's co 01/28/25 at 11:58ar -Resident #1's Dorz 06/03/24 and 07/08 each dispensing. -A refill was receive medication would b 01/29/25. -Dorzolamide-timol pressure in the eye Interview with Resid revealed:	zolamide-timolol was filled on 1/24 for a 38-day supply on 2d on 01/27/25 and the 3e delivered to the facility on 3e ol was used to reduce 5e dent #1 on 01/28/25 at 1:04pm 3e eye drops in a long time.				

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DIVISION	Division of Health Service Regulation							
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		FCL032096	B. WING		R 01/31/202			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE				
	FAMILY HOME	2122 OVE	RLAND DRIV , NC 27704					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
{C 330}	Continued From page 55		{C 330}		-			
	-His vision was getting "worse and worse." -His vision was blurredHis eyes did not hurt, and he did not have any headaches.							
	Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 1:06pm revealed: -He looked at Resident #1's MARs and compared them to the medications on hand when he started on 01/20/25. -If the medication was available, he put a checkmark and if he needed to order the medication, he put an "x." -He administered Resident #1's Dorzolamide-timolol eye drops every day he worked. -He administered Resident #1's Dorzolamide-timolol today, 01/28/25.							
	Dorzolamide-timolo he had used to adm -He could not say w	hy Resident #1 still had of from the July 2024 refill that ninister to the resident. That anyone else had done, ed his initials that meant the ministered.						
	MAR from 01/01/25 check marks and/or	desident #1's January 2025 5-01/28/25 revealed there were r an X mark on multiple was no mark beside Resident molol eye drops.						
	01/29/25 at 12:24pr Dorzolamide-timolo	w with the Administrator on m revealed if Resident #1's oll had been documented as would not have known he was drops as ordered.						

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Telephone interview with Resident #1's primary

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						3
		FCL032096	B. WING	· · · · · · · · · · · · · · · · · · ·	01/3	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		ERLAND DRI	VE		
0.0.15	CLIMANA DV CTA		, NC 27704	DDOVIDEDIC DI ANI OF CODDECTION	DNI .	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ontinued From page 56				
	revealed: -Resident #1's Dorz should be administed. The last time she was Dorzolamide-timolo. Attempted telephon Ophthalmologist on unsuccessful. Refer to the telephon Manager on 01/28/2	wrote a refill for Resident #1's I eye drops was in 2023. The interview with Resident #1's 01/28/25 at 3:03pm was the interview with the House 25 at 3:50pm. The interview with the House 25 at 3:50pm.				
	on 01/29/25 at 10:3 Refer to the telepho Administrator on 01	one interview with the				
	revealed there was plus (a prescription	ent #1's May 2024 MAR an entry for Prevident 5000 fluoride toothpaste), brush for laily, and then spit out.				
	revealed: -There was an entry brush for two minut with a scheduled ac and 8:00pm There was docum administered twice Review of Resident revealed:	#1's November 2024 MAR y for Prevident 5000 plus, es twice daily and then spit out dministration time of 8:00am entation Prevident 5000 was daily from 11/01/24-11/30/24. #1's December 2024 MAR y for Prevident 5000 plus,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		R	
		FCL032096	B. WING		1	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
JONES F	FAMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{C 330}	with a scheduled and and 8:00pm. - There was docum administered twice Review of Resident 01/01/25-01/28/25 and 8:00pm. - There was an entribrush for two minut with a scheduled and 8:00pm. - There was docum administered twice Observation of Reshand on 01/28/25 ano Prevident 5000 administered. Telephone interview from the facility's con 1/28/25 at 11:58ar-Prevident 5000 to which could help prevident #1's Prevident #1's Prevident #2's	es twice daily and then spit out dministration time of 8:00am entation Prevident 5000 was daily from 12/01/24-12/31/24. E #1's January 2025 MAR from revealed: y for Prevident 5000 plus, es twice daily and then spit out dministration time of 8:00am entation Prevident 5000 was daily from 01/01/25-01/28/25. E #1's January 2025 MAR from revealed: y for Prevident 5000 plus, es twice daily and then spit out dministration time of 8:00am entation Prevident 5000 was daily from 01/01/25-01/28/25. E #1's January 2025 MAR from revealed then spit out dministration time of 8:00am entation Prevident 5000 was daily from 01/01/25-01/28/25. E #1's January 2025 MAR from revealed: between the spit out of the	{C 330}			
	revealed: -He used to use too	othpaste his dentist ordered.				

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DIVISION	of Health Service Re	egulation				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	
		FCL032096	B. WING		01/3	1/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
IONES	AMILY HOME	2122 OVE	RLAND DRI	VE		
JUNES	AWILT HOWE	DURHAM	NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 330}	Continued From pa	ge 58	{C 330}			
	-He had not had "th	at" toothpaste in a long time. othpaste was going to be , 01/29/25.	,			
	revealed: -He looked at Residit to the medications 01/20/25If the medication with the medication, he put a resident #1 had "j Prevident was why -Resident #1 had be toothpaste every date.	ust finished up" his tube of there was none on hand. een using the Prevident ay as ordered.				
	-He did not know w Prevident toothpast for him to administe -He could not say w	hy Resident #1 still had e from the August 2024 refill er to the resident. hat anyone else had done, ed his initials that meant the				
	MAR from 01/01/25 check marks and/o	esident #1's January 2025 i-01/28/25 revealed there were r an X mark on multiple was no mark beside Resident npaste.				
	01/28/25 at 3:31pm -He ordered Previdence Resident #1 because cavities and addition in preventing addition	ent 5000 toothpaste for se the resident had a history of nal fluoride could be proactive				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL032096	B. WING			R 31/2025
	PROVIDER OR SUPPLIER	2122 OVE	DDRESS, CITY, S ERLAND DRIV I, NC 27704	TATE, ZIP CODE /E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{C 330}	Telephone interviev	v with the Administrator on	{C 330}			
	01/29/25 at 12:24pm revealed if Resident #1's Prevident toothpaste had been documented as administered she would not have known he was not using the toothpaste as ordered.					
	01/28/25 at 4:16pm -Resident #1's teeth condition.	n were not in the best ident #1's Prevident				
	Refer to the telepho Manager on 01/28/2	one interview with the House 25 at 3:50pm.				
	Refer to the telepho Manager on 01/29/2	one interview with the House 25 at 9:44am.				
	Refer to the telepho on 01/29/25 at 10:3	one interview with the Director 2am.				
	Refer to the telepho Administrator on 01	one interview with the //29/25 at 12:24pm.				
	revealed: -Diagnoses include and implantable cal -There was an orde	ent #3's FL-2 dated 01/24/25 d heart failure, hypertension rdioverter defibrillator. er for Prednisone (a steroid mation) 20mg, take 2 tablets				
	01/01/25-01/28/25 i -There was an entr	tration record (MAR) from revealed: y for Prednisone 20mg take ys with a scheduled				

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Division	of Health Service Re		T		1	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LEIED
					F	₹
		FCL032096	B. WING		01/31/2025	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
NAIVIL OI I	-NOVIDEN ON SUFFEIEN					
JONES F	AMILY HOME		RLAND DRI	V C		
			, NC 27704			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
{C 330}	Continued From pa	ge 60	{C 330}			
	-There was documentation Prednisone 20mg was administered daily from 01/01/25-01/28/25.					
	Observation of Res	ident #3's medications on				
		t 10:41am revealed there was				
	no Prednisone 20m					
	administered.					
	Telephone interview with a pharmacy technician					
		ontracted pharmacy on				
	01/28/25 at 11:58ar					
		ne order in their system for ednisone 20mg, take two				
		ays; the order was received on				
	11/23/24.	dys, the order was received on				
	-Eight tablets of Pre	ednisone 20mg were				
	dispensed and had					
	Resident #3's FL-2	I not received a copy of dated 01/24/25.				
		d a copy of the FL-2 all				
		on the FL-2 would have been				
	filled.					
		sident #3's Prednisone 20mg				
	should be administed the FI -2	ered every four days based on				
	110 1 L Z.	have been filled as ordered on				
	the FL-2.	nave been filled as ordered off				
İ	1. ((010)				
		Supervisor-in-Charge (SIC) on				
		revealed he did not do lent #3's FL-2, the House				
	Manager was respond					
	Telenhone interview	v with the House Manager on				
	01/28/25 at 3:50pm					
		who completed Resident #3's				
		the primary care provider				
	(PCP), but he thoug					
	-He had taken Resi	dent #3 to the PCP and when				
	he returned to the f	acility he gave the FL-2 to the				

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	or realtribervice ite		0.60			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	-		A. BUILDING:			
		FCL032096	B. WING		01/3	₹ 1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IONEO E		2122 OVE	RLAND DRI	VE		
JUNES F	AMILY HOME	DURHAM,	NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{C 330}	Continued From page 61		{C 330}			
	SIC working. -The SIC was respond to the medications of anything did not made contacted the PCP. -He did not know if medications on handle and the PCP. Resident #3 on a new know what the medication pharmacy; the PCP pharmacy to send to the pharmacy to send to the pharmacy to send the pharmacy the pharmac	onsible for comparing the FL-2 on hand and the MAR and if atch, the SIC should have the new FL-2 matched the ad and/or the MAR. Property stating he was starting the was starting to we medication, but he did not ication was. On was going to be sent to the confirmed the name of the he order. We with the Director on 01/29/25 did the House Manager was the wing the FL-2 and making				
	Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -New FL-2s should be faxed to the pharmacyShe was not aware Resident #3 had an order for Prednisone on his FL-2 that had not been implementedShe was concerned the FL-2 was not faxed to the pharmacy and no one had followed up with the doctor who ordered the medication. Attempted telephone interview with Resident #3's PCP on 01/28/25 at 2:45pm was unsuccessful. Refer to the telephone interview with the House Manager on 01/28/25 at 3:50pm. Refer to the telephone interview with the House Manager on 01/29/25 at 9:44am.					
	Refer to the telepho on 01/29/25 at 10:3	one interview with the Director 2am.				

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QYIW12 If continuation sheet 62 of 77

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL032096	B. WING			R 31/2025
	PROVIDER OR SUPPLIER	2122 OVE	DRESS, CITY, S RLAND DRIV , NC 27704	TATE, ZIP CODE /E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{C 330}		one interview with the	{C 330}			
	o1/28/25 at 3:50pm anything about the process; the Director question. Telephone interview 01/29/25 at 9:44am -At the beginning of	f the month, the medications pared to the residents' MAR to tched.				
	Telephone interview at 10:32am reveale -Staff should compared medications on har -Staff should look a sure they matched the medication to the -He did not recall wadministered to the so many different fawas neededHe had serious control of the serious	w with the Director on 01/29/25 d: are the MAR with the od. the medications and make the MAR before administering				
	O1/29/25 at 12:24pr -She expected the as ordered. -She expected the	staff to administer medications staff to compare the I to the MAR administer the				

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STATE FORM 6899 QYIW12 If continuation sheet 63 of 77

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			,
		FCL032096	B. WING		01/3	1/2025
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{C 330}	was at the facility in -She did not look at make sure the med facility. The facility failed to ordered for 3 of 3 sadministering a stemedication was only days and the resident nervous which could administration of the resident who had a had not been admir for more than 5 more sident's risk of incand a resident who the medication had failure was detriment well-being of the resident. The facility provided	esidents' MARs when she	{C 330}			
		N DATE FOR TH TYPE B . NOT EXCEED MARCH 17,				
{C 342}	(j) The resident's m	004 Medication Administration nedication administration be accurate and include the	{C 342}			

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STATE FORM 6899 QYIW12 If continuation sheet 64 of 77

Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					F	₹
		FCL032096	B. WING		01/31/2025	
					1 00	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI	VE		
		DURHAM	, NC 27704			
(X4) ID		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
{C 342}	Continued From pa	ge 64	{C 342}			
(·		(5 5)			
		dication or treatment order;				
	(3) strength and do					
	medication adminis	administering the medication				
	or treatment;	duministering the medication				
		cation for the administration of				
		tments as needed (PRN) and				
		sulting effect on the resident;				
	(6) date and time of administration;					
	(7) documentation of any omission of					
		tments and the reason for the				
	omission, including					
		of the person administering eatment. If initials are used, a				
		t to those initials is to be				
	•	aintained with the medication				
	administration reco					
		,				
	This Rule is not me					
		ons, interviews, and record				
	reviews, the facility					
		tration records were accurate				
		residents (#1, #3) including a treat constipation and an				
		1); and a medicated shampoo				
	(#3).	1), and a modification originates				
	(/-					
	The findings are:					
	4. Daview of David	ant #41a accompant EL O detect				
		ent #1's current FL-2 dated				
	05/03/24 revealed:	d hypertension, osteoarthritis,				
		e, anemia, gastroesophageal				
		p apnea, chronic obstructive				
		vitamin D deficiency,				
		nic paranoid schizophrenia.				
	-There was docume	entation for medication to see				
	the medication adm	ninistration record (MAR).				
	a. Review of Reside	ent #1's May 2024 MAR				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		FCL032096	B. WING		01/3	1/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	D BE	(X5) COMPLETE DATE
{C 342}	Continued From page 65		{C 342}			
	revealed an entry for Miralax powder (used to treat constipation) one capful in 8 ounces of water once daily.					
	revealed: -There was an entry daily with a schedul 8:00am.	#1's November 2024 MAR y for Miralax one capful once ed administration time of entation Miralax was at 8:00am from				
	Review of Resident #1's December 2024 MAR revealed: -There was an entry for Miralax one capful once daily with a scheduled administration time of 8:00amThere was documentation Miralax was administered daily at 8:00am from 12/01/24-12/31/24.					
	01/01/25-01/28/25 range -There was an entry daily with a schedul 8:00am.	y for Miralax one capful once ed administration time of entation Miralax was				
	hand on 01/28/25 a	ident #1's medications on t 9:30am revealed a bottle of ensed date of 06/24/24; the in three-fourths full.				
	from the facility's co 01/28/25 at 11:58ar	with a pharmacy technician ontracted pharmacy on revealed Resident #1's n 05/06/24 and 06/24/24 for a				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FOI 000000	B. WING		F	
FCL032096			D. WING		01/3	1/2025
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI' , NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETE DATE
{C 342}	Continued From page 66		{C 342}			
	30-day supply.					
	revealed: -He did not know if beverage in the mo	y problems with his bowels				
	Interview with the S 01/28/25 at 1:06pm -He administered R 01/28/25He had administer day he workedHe did not know w fullMaybe someone h MiralaxHe could not say w	supervisor-in-Charge (SIC) on revealed: lesident #1's Miralax today, led Resident #1's Miralax every hy the Miralax bottle was still ad used another resident's what anyone else had done, led his initials that meant the				
	technician from the on 01/28/25 at 11:5	one interview with a pharmacy facility's contracted pharmacy 8am.				
	Manager on 01/29/2					
	on 01/29/25 at 10:3					
	Refer to the telepho Administrator on 01	one interview with the //29/25 at 12:24pm.				
	revealed an entry fo	ent #1's May 2024 MAR or Clotrimazole 1% topical pal cream) apply to toes twice				

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daily.

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STATE FORM

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
		FCL032096	B. WING			R 31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE	-	
JONES I	FAMILY HOME		ERLAND DRIV I, NC 27704	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 67	{C 342}			
	revealed: -There was an entry cream apply to toes administration time -There was docume topical cream was a 8:00pm from 11/01// Review of Resident revealed: -There was an entry cream apply to toes administration time -There was docume topical cream was a 8:00pm from 12/01// Review of Resident 01/01/25-01/28/25 -There was an entry cream apply to toes administration time -There was an entry cream apply to toes administration time -There was an entry cream apply to toes administration time -There was docume topical cream was a 8:00pm from 01/01/01/01/01/01/01/01/01/01/01/01/01/0	a #1's December 2024 MAR by for Clotrimazole 1% topical by twice daily with a scheduled of 8:00am and 8:00pm. bentation Clotrimazole 1% applied daily at 8:00am and by for Clotrimazole 1% by for Clotrimazole 1% topical by twice daily with a scheduled of 8:00am and 8:00pm. bentation Clotrimazole 1% applied daily at 8:00am and by for Clotrimazole 1% applied daily at 8:00am and by for 25-01/28/25. by for Clotrimazole 1% by for Clotrimazole 1% contracted a tube of the form of				

Division of Health Service Regulation

Division of Health Service Regulation		1				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAIN	OF CONNECTION	IDENTIFICATION NOWDER.	A. BUILDING:			LLILD
					R	
		FCL032096	B. WING		01/3	1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TW TWIL OT	NOVIDER OR GOLF EIER		RLAND DRI	,		
JONES F	AMILY HOME		, NC 27704	v C		
	OUR MAA EN COTA					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEFICIENCY)		
{C 342}	Continued From page 68		{C 342}			
	discontinued order, so it continued to be on the MAR.					
		dent #3 on 01/28/25 at 5:08pm				
	-	ply cream to his feet every				
	day.	w problems with his fast that				
	needed cream.	y problems with his feet that				
	Interview with the S revealed:	IC on 01/28/25 at 1:06pm				
	-He applied cream to	to Resident #1's toes twice a				
		to Resident #1's toes today,				
	-It only took a small #1's toes.	amount to apply to Resident				
		hat anyone else had done,				
	but if he documente medication was adr	ed his initials that meant the ministered.				
		one interview with a pharmacy				
	on 01/28/25 at 11:5	facility's contracted pharmacy 8am.				
	Refer to the telepho Manager on 01/29/2	one interview with the House 25 at 9:44am.				
	Refer to the telepho on 01/29/25 at 10:3	one interview with the Director 2am.				
	Refer to the telepho Administrator on 01	one interview with the /29/25 at 12:24pm.				
	revealed:	ent #3's FL-2 dated 01/24/25				
	and implantable car	d heart failure, hypertension, dioverter defibrillator. for Ketoconazole 2%				

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DIVISION	Division of Health Service Regulation						
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL032096	B. WING		R 01/31/2025		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
JONES F	FAMILY HOME		RLAND DRI	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
{C 342}	Continued From pa	ge 69	{C 342}				
	shampoo (used to treat fungal infections of the scalp) twice weekly.						
	01/24/25-01/28/25 -There was an entry shampoo apply twid administration time -There was docume shampoo was appli Observation of Reshand on 01/28/25 a	y for Ketoconazole 2% be weekly with a scheduled of 8:00am. entation Ketoconazole 2%					
	from the facility's co 01/28/25 at 11:58ar -Resident #3's Keto on 03/26/24; there -The order was for twice weekly. -It depended on hor as to how long it wo four-ounce bottle so approximately 30 december 10.000 constraints	was no other dispensing. Ketoconazole to be applied w much was used each time ould last but it was only a o would only last					
	revealed he had a 'been cleared up 'fo Interview with the S 01/28/25 at 2:01pm -Resident #3's infec	spot" on his head but it had but					
		ppoo "the other dav."					

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QYIW12 If continuation sheet 70 of 77

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			D	
		FCL032096	B. WING			R 31/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
JONES F	FAMILY HOME		RLAND DRIV , NC 27704	VE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
{C 342}	Continued From pa	nge 70	{C 342}				
	Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am.						
	Refer to the telepho Manager on 01/29/	one interview with the House 25 at 9:44am.					
	Refer to the telephone interview with the Director on 01/29/25 at 10:32am. Refer to the telephone interview with the Administrator on 01/29/25 at 12:24pm.						
	Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed: -The purpose of MARs was to document medications as administeredThe MAR should be used to show what medication was given on what day and at what timeThe MARs should match the medications on handThe MAR should match the medication labelAny exceptions should be documented on the MAR.						
	01/29/25 at 9:44am -The staff member should compare the hand and after adm document on the M -If a medication wa administered every paying attention and the staff were not the did not do MAF	administering the medication e MAR to the medication on ninistering the medication, IAR. s being documented as day the staff member was not d "just documenting." taking time to read the MAR.					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		FCL032096	B. WING		01/3	R 1/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES F	AMILY HOME		RLAND DRI	VE		
0(0) ID	CLIMANA DV CTA	TEMENT OF DEFICIENCIES	, NC 27704	DDOVIDEDIS DI ANI OF CORDECTI	ON	()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{C 342}	Continued From pa	ge 71	{C 342}			
	medications on han -Staff should look a sure they matched the medication to the -Staff should only deadministered. Telephone interview 01/29/25 at 12:24pr -She expected the semedication on hand medication and the -She reviewed the reviewed the reviewed the reviewed the semedication to hand medication and the she reviewed the re	are the MAR with the id. It the medications and make the MAR before administering the residents. It is comment the medications It with the Administrator on the revealed: It othe MAR administer the in document. It is it is the index of the				
0.007	facility.		0.007			
C 367	10A NCAC 13G .10	08(a) Controlled Substances	C 367			
	(a) A family care he retrievable record o documenting the re disposition of controrecords shall be ma	08 Controlled Substances ome shall assure a readily f controlled substances by ceipt, administration and olled substances. These wintained with the resident's an order that there can be ion.				
	interviews, the facili readily retrievable re substances by docu administration, and	et as evidenced by: ons, record reviews, and ity failed to ensure there were ecords for controlled umenting the receipt, disposition for 1 of 1 sampled n order for a medication used				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		1, ,		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:		R	
	FCL032096	B. WING			1/2025
NAME OF PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	TATE, ZIP CODE		
JONES FAMILY HOME		RLAND DRI\ NC 27704	/E		
PREFIX (EACH DEFICIENCY MUST	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE
C 367 Continued From page 72	Continued From page 72				
The findings are: Review of Resident #1's 05/03/24 revealed: -Diagnoses included hyp Parkinson's disease, and reflux disease, sleep apropulmonary disease, vitangingivitis, and chronic pathere was documentation administrication	Review of Resident #1's current FL-2 dated 05/03/24 revealed: -Diagnoses included hypertension, osteoarthritis, Parkinson's disease, anemia, gastroesophageal reflux disease, sleep apnea, chronic obstructive pulmonary disease, vitamin D deficiency, gingivitis, and chronic paranoid schizophreniaThere was documentation for medication to see the medication administration record (MAR). Review of Resident #1's May 2024 MAR revealed an entry for Clonazepam (used to treat anxiety) 0.5mg take one tablet three times daily. Review of Resident #1's November 2024 MAR revealed: -There was an entry for Clonazepam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pmThere was documentation Clonazepam 0.5mg was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 11/01/24-11/30/24. Review of Resident #1's controlled substance count sheet (CSCS) revealed: -There was a CSCS with a pharmacy label that read Clonazepam 0.5mg three times dailyThe pharmacy label read there were 90 tablets of Clonazepam 0.5mg dispensed on 10/30/24A handwritten note on one of the three CSCS was documented as started on 11/04/24The form was filled in with dates and times of 8:00am, 3:00pm, and 8:00pm from				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R		
FCL032096		B. WING		1	1/2025	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
IONES E	AMILY HOME	2122 OVE	RLAND DRI	VE		
JONES	AMILI HOML	DURHAM,	NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 367	8:00pm and 11/11/2 -There was no sign 8:00pm doses on 1 2:00pm, and 8:00pi -The second CSCS the date of 11/14/24 11/24/24 for the 8:0 -There was no door dose administered -The third CSCS da 11/24/24 at 8:00pm the 2:00pm doseThere was no door dose administered Review of Resident revealed: -There was an entri times daily with a so of 8:00am, 2:00pm, -There was docume was administered tt 2:00pm, and 8:00pi Review of Resident -There was a CSCS read Clonazepam 0 -The pharmacy labo of Clonazepam 0.5 -The form was filled dates and times Clo from 12/11/24 at 2: -There was docume Clonazepam 0.5mg #1 on 12/11/24 at 2 8:00am, 2:00pm, at 12/12/24-12/20/24 -The CSCS ended	24 at 8:00am. ature for the 2:00pm and 1/11/24 and at 8:00am, m from 11/12/24-11/13/24. dated 10/30/24 started with at 2:00pm and ended on 0am dose. umentation for the 8:00am on 11/14/24. ated 10/30/24 started on and ended on 12/04/24 for umentation for the 2:00pm on 11/24/24. at 1's December 2024 MAR of or Clonazepam 0.5mg three cheduled administration time and 8:00pm. antation Clonazepam 0.5mg hree times daily at 8:00am, m from 12/01/24-12/31/24. at 1's CSCS revealed: at with a pharmacy label that at 1.5mg three times daily. at 1 read there were 90 tablets and dispensed on 12/09/24. at in three times a day for the and administered and an inistered an inistere	C 367			
		4 at 2:00pm and ended on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			R
		FCL032096	B. WING			31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
L JONES FAMILY HOME			RLAND DRI' NC 27704	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
C 367	12/31/24 for the 8:0-The third CSCS da 12/31/24 at 3:00pm 8:00amThere was no door 0.5mg was adminis and three times dai the 12/11/24 8:00am Review of Resident 01/01/25-01/27/25 -There was an entr times daily with a sof 8:00am, 2:00pm -There was docume was administered to 12:00pm, and 8:00pm Review of Resident 8:37am revealed: -There was a CSCS read Clonazepam 0.5 -The form was filled dates and times Clofrom 01/10/25 at 2:01/20/25 at 8:00am -There was no sign 8:00pm doses on 02:00pm, and 8:00pm on 91/20/25 at 8:00pm on 91/20/25 at 8:00pm -There was no sign 8:00pm doses on 03:00pm doses on 03:	Joam dose. Ated 12/09/24 started on and ended on 01/10/25 at atered on 12/04/24 at 8:00pm by from 12/05/24-12/10/24 and mose. At #1's January 2025 MAR from revealed: Y for Clonazepam 0.5mg three cheduled administration time and 8:00pm. At #1's CSCS on 01/28/25 at at a pharmacy label that 0.5mg three times daily at 8:00am, and from 01/01/25-01/27/25. At #1's CSCS on 01/16/25 at a pharmacy label that 0.5mg three times daily. At #1's CSCS on 01/16/25 at a pharmacy label that 0.5mg three times daily. At #1's CSCS on 01/16/25 at a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm with an end dated of 1. At #1's CSCS on 01/16/25. At a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm with an end dated of 1. At a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm with an end dated of 1. At a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm with an end dated of 1. At a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm with an end dated of 1. At a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm with an end dated of 1. At a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm with an end dated of 1. At a pharmacy label that 0.5mg three times a day for the conazepam was administered 0.0pm and 1.10/25 and at 8:00am, m from 0.1/11/25-0.1/19/25 and 1. At a pharmacy label that 0.5mg three times daily.	C 367			

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STATE FORM

DIVISION	of Health Service Re	eguiation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		FCL032096	B. WING		R 01/31/2025	
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
10.000	2122 OVERLAND DRIVE					
JONES F	FAMILY HOME	DURHAM	NC 27704			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE
C 367	Continued From pa	ge 75	C 367			
	0.5mg tablets with a was labeled as 2 of -There were 7 of 30 remaining in the bu Second observation on hand on 01/29/2 -There was a second Clonazepam 0.5mg of 01/16/25; it was likely as 1 was	D Clonazepam 0.5mg bble pack. In of Resident #1's medications 5 at 11:45am revealed: Ind bubble pack of 30 In tablets with a dispense date Inabeled as 3 of 3.				
	-There were 30 of 30 Clonazepam 0.5mg remaining in the bubble pack. Telephone interview with the pharmacy technician					
	01/29/25 at 1:02pm -The pharmacy had for Resident #1's C three times dailyResident #1's Clordispensed on 10/30	ontracted pharmacy on revealed: I an ordered dated 10/24/24 lonazepam 0.5mg one tablet lazepam 0.5mg was 0/24,12/09/24, and 01/16/25; as 90 tablets for a 30-day				
	revealed: -He signed the CSC medicationAs long as he sign the CSCS was sign -The MAR was the -When asked why for the controlled m	ge on 01/29/25 at 11:38am CS when he administered the ed the MAR, it did not matter if ed.				
	Telephone interview	wwith the House Manager on				

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01/29/25 at 9:44am revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		FCL032096	B. WING			R 31/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
JONES FAMILY HOME 2122 OVERLAND DRIVE DURHAM, NC 27704						
(VA) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORR	ECTION	(V5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
C 367	Continued From pa	ge 76	C 367			
	-When a staff mem medication, it shoul resident's MAR and -The CSCS was no documented every administration. Telephone interview at 10:32am reveale administration of co same as all medica also documented of Telephone interview	ber administered a controlled d be documented on the lon the CSCS. t prefilled and should be day at the time of the with the Director on 01/29/25 d documenting the entrolled medications was the tions, but to make sure it was in the CSCS.				
	including the CSCS -She was not aware November 2024 and was not signed whe administered.	ent #2's controlled medication, in December 2024. The there were days in d December 2024 the CSCS on the medication was did that controlled medications				

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