STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032096	A. BUILDING: _____ B. WING _____	R 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES FAMILY HOME	2122 OVERLAND DRIVE 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 SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments 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 000}		
{C 078}	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to be maintained in a clean and orderly manner, and free of hazards, related to live and dead bed bugs observed in a resident's bedroom and live and dead roaches observed in the dining room. The findings are: Review of the facility's Environmental Health Inspection report dated 01/06/25 revealed: -There were 9 total demerits. -Demerits included floors and carpet in good repair, walls, ceilings, and attachments in good repair, handwashing provided, and pest presence. -Pests should not be present in a residential care	{C 078}		

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{C 078}	Continued From page 1	{C 078}		

facility.
-Be sure to remove dead pests to prevent harborage.

1. Observation of the dining room on 01/28/25 at 8:10am revealed multiple dead roaches on the dining room floor beside 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 room.
-He had not told the Director he had seen live roaches because he assumed the Director had seen them.

Telephone interview with a representative from the facility's contracted pest control company on 01/18/25 at 12:44pm revealed:
-The facility had not been treated for roaches by their company.
-The facility had not requested pest treatment.
-The facility could be treated for roaches, but the staff would need to request pest treatment.

Telephone interview with the county Environmental Health Specialist on 01/29/25 at 8:25am revealed:
-She saw live and dead roaches at the facility on 01/06/25.
-Roaches carried diseases.
-Dead roaches needed to be cleaned up because

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{C 078}	Continued From page 2	{C 078}		

live roaches ate lives ones.
-Not cleaning up dead pests was considered harborage (in pest control, harborage referred to the locations and conditions where pests could live, thrive, and reproduce).
-Roaches would keep "coming around" if not cleaned up.

Telephone interview with the House Manager on 01/29/25 at 9:44am revealed:
-He had seen roaches at the facility, "now and then."
-The staff had been treating the roaches using a [named] spray that was safe to use around the residents.
-He could not make the decision to use a pest control company.
-The staff working usually sprayed at night.

Telephone interview with the Director on 01/29/25 at 10:32am revealed:
-The staff had been treating the facility for roaches.
-He used a [named] safe spray once a month to treat the roaches.
-He thought the spray was working because the roaches had been "bad' but were getting better.
-He had not called the pest control company to treat the roaches.
-He had not read the Environmental Health report dated 01/06/25.
-Cleaning the facility was an ongoing process to clean up dead pests.
-If the SIC did not clean up the dead roaches on 01/28/25, it was probably because he was "nervous" because the surveyor was in the facility.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/29/25 at

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{C 078}	Continued From page 3	{C 078}		

11:59am revealed:
-She had seen live roaches at the facility.
-Roaches carried disease and were not sanitary. She thought the facility needed to be professionally exterminated.

Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed:
-The staff had not notified her of the presence of roaches.
-The staff should have let her know they had seen roaches.

Telephone interview with the Administrator on 01/30/25 at 9:57am revealed she expected the SIC to clean up dead roaches daily, as often as they saw them.

According to the United States Environmental Protection Agency (EPA) publication dated 10/28/24 revealed roaches and their droppings may trigger an asthma attack. Their feces, saliva, eggs, outer covering, or cuticles left behind on surfaces contained substances that were allergenic to humans, especially those with asthma or other respiratory conditions. Within and on the surface of their bodies, roaches carried bacteria that could cause salmonella, staphylococcus, and streptococcus if deposited in food.

Refer to the telephone interview with the SIC on 01/29/25 at 11:38am.

Refer to the telephone interview with the Administrator on 01/29/25 at 12:24pm.

2. Interview with a resident on 01/18/25 at 8:12am revealed there were two [named] residents who still had bed bugs in their room.

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{C 078}	Continued From page 4 Interview with a second resident on 01/28/25 at 8:15am revealed: -He had bed bugs in his room, "they were bad." -The bed bugs crawled up on his bed. -He had not been bitten by the bed bugs. -The facility "fumed" the facility a "couple of months back." -He did not like having bed bugs in his bed. Interview with a third resident on 01/28/25 at 8:17am revealed: -He had bed bugs in his room. -He had been bitten by bed bugs in his room, but it was a long time ago, in the summer of 2024. -He did not like having bed bugs. Observation of the resident's room on 01/28/25 at 9:49am revealed: -There were two beds in the room, a bed on the left-hand side of the room and a second bed on the right-hand side of the room. -There were live bed bugs observed crawling on the bed linen on the bed to the right-hand side of the room. -There were dead bed bugs on the floor by both residents' beds. Observation of a second resident's room on 01/28/25 at 9:53am revealed there were a large number of dead bugs on the floor on both sides of the resident's bed. Interview with the resident who resided in this resident room on 01/28/25 at 9:53am revealed: -He bought his own spray to use in his room. -Since he had been spraying his own room, he had not seen any live bed bugs, but there were dead bugs because the spray was working.	{C 078}		

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{C 078}	Continued From page 5	{C 078}		

Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 10:00am revealed:
-The pest control company was scheduled to come to the facility to treat the bed bugs on 01/30/25.
-He did not know when the pest control company was last at the facility.
-He told the House Manager he had seen live bed bugs, and the House Manger said, "he knew."
-He did not know when he told the House Manager, but it had been since 01/20/25 when he started "back" working at the facility.

Telephone interview with a representative from the facility's contracted pest control company on 01/18/25 at 12:44pm revealed:
-The facility was treated for bed bugs on 11/21/24.
-They received a call on 01/16/25 to treat bed bugs and it was scheduled for 01/24/25.
-They received a call from someone at the facility to reschedule the treatment because a staff member was sick, and the treatment was rescheduled for 01/30/25.
-They had not received any calls about live bed bug activity prior to 01/16/25.

Telephone interview with the county Environmental Health Specialist on 01/29/25 at 8:25am revealed:
-She did not see live bed bugs when she was at the facility.
-Bed bugs needed to be exterminated and cleaned up.

Telephone interview with the House Manager on 01/29/25 at 9:44am revealed:
-He was made aware of the bed bugs at the facility two months ago.
-He had seen bed bugs in the corner of the wall in

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{C 078}	Continued From page 6	{C 078}		

the hallway about 2-3 weeks ago.
-The pest control company was called when he saw the bed bugs, but they could not come out immediately and he had to make an appointment.
-He was sick and had to reschedule the appointment as he was the staff member who needed to be at the facility to coordinate having the residents out of the facility for the day.

Telephone interview with the Director on 01/29/25 at 10:32am revealed he knew there were live bed bugs at the facility and the pest control company had been contacted and was scheduled to go to the facility.

Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed:
-The staff had not notified her of any live bed bugs.
-She was not aware the facility had active bed bugs.
-The staff should have let her know they had seen bed bugs.

Telephone interview with the Administrator on 01/30/25 at 9:57am revealed she expected the SIC to clean up dead bed bugs daily, as often as they saw them.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/29/25 at 11:59am revealed:
-Live bed bugs in the facility increased the resident's risk for bites.
-If a resident was bitten by a bed bug, the resident could scratch the bite, which put the resident at risk for an infection.

According to the North Carolina Department of Health and Human Services guidelines dated

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{C 078}	Continued From page 7 March 2024 revealed bed bugs could cause skin irritation which could lead to scabbing and possible infection, allergic reactions, and increased stress from skin irritation and lack of sleep. Refer to the telephone interview with the SIC on 01/29/25 at 11:38am. 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 day. -He had not done pest control at the facility. -He swept the facility every morning and every evening. -If he saw dead pests, he swept them up. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -The Director needed to have a pest company come out and treat the facility. -The facility needed professional treatment. -She was concerned that the facility had pests because it was not good for the residents' health. _____ The facility failed to ensure a clean and orderly environment free from hazards related to dead roaches in the dining room and active bedbugs in one resident's room. Pests, including roaches and bed bugs in the facility increased the residents' risk of disease and infections, which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	{C 078}		

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{C 078}	Continued From page 8 The facility provided a plan of protection in accordance with G.S. 131D-34 on 001/31/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 17, 2025.	{C 078}		
{C 100}	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure at least four fire drills were held annually. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire drills documentation revealed:	{C 100}		

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{C 100}	Continued From page 9 -There was documentation of a completed fire drill in which all the residents were able to evacuate the facility dated 12/09/23. -There was documentation of a completed fire drill in which all the residents were able to evacuate the facility dated 12/23/23. -There was no documentation of completed fire drills for 2024. 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 porch. -All the residents were able to evacuate the facility without staff assistance in less than three minutes. -The residents met at the designated zone outside the facility. Interview with a resident on 01/28/25 at 8:12am revealed: -Fire drills were rare. -He could not recall the last time the facility had a fire drill, but it was before the holidays. Interview with a second resident on 01/28/25 at 8:15am revealed: -It had been "several" months since they had a fire drill, but he could not recall exactly when. -All the residents "got out okay." Interview with a third resident on 01/28/25 at 8:17am revealed they had a fire drill a "long time ago", he thought it was back in the summer of 2024. Interview with the Supervisor-in-Charge (SIC) on 01/18/25 at 3:38pm revealed: -Whoever performed a fire drill should complete a fire drill log and put it in the notebook.	{C 100}		

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{C 100}	Continued From page 10 -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 facility. -He 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. Telephone interview with the Administrator on 01/30/25 at 9:57am revealed the SIC was responsible for performing fire drills; a fire drill log should be completed.	{C 100}		
{C 131}	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.	{C 131}		

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{C 131}	Continued From page 11 This Rule is not met as evidenced by: Follow-Up to a Type B Violation The Type B Violation was abated. Deficient practice continues. Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (A) who administered medications, completed a medication clinical skills checklist, and had documentation of a completing the 5, 10, or 15-hour medication aide (MA) training course or had verification she had previously worked as a MA before administering medication to residents. The findings are: Review of Staff A's personnel record revealed: -There was no signed job description or hire date. -There was no medication clinical skills checklist. -There was no certificate for the 5, 10, or 15-hour MA training course or verification she had previously worked as an MA. -There 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 the sister facility on 01/29/25 at 1:21pm revealed:	{C 131}		

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{C 131}	Continued From page 12 -Staff A worked at multiple sister facilities. -Staff A had completed all required MA training, including the 15-hour course and the medication clinical skills checklist. -She could not find a copy of Staff A's medication training paperwork. Telephone interview with the Director on 01/29/25 at 1:35pm revealed: -Staff A had completed all required MA training. -He would have the House Manager at the sister facility send a copy of Staff A's completed MA training. 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 interviews it was determined Staff A was unable to be interviewed. Attempted telephone interview with the Administrator on 01/30/25 at 2:57pm was unsuccessful.	{C 131}		
{C 145}	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 3 sampled staff	{C 145}		

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{C 145}	Continued From page 13 (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 date. -There 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 facilities. -Staff A had a HCPR check completed upon hire. -She 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 completed. -He would have the House Manager at the sister facility send a copy of Staff A's completed HCPR check. Requests for Staff A's HCPR check results on 01/28/25 and 01/29/25 were not provided by the survey exit date. Based on interviews it was determined Staff A was unable to be interviewed. Attempted telephone interview with the Administrator on 01/30/25 at 2:57pm was unsuccessful.	{C 145}		
{C 147}	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications	{C 147}		

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{C 147}	Continued From page 14 (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 or 3 sampled staff (A) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -There was no signed job description or hire date. -There was no documentation of a criminal background 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 facilities. -Staff A had a background check completed. -She could not find a copy of Staff A's background check. Telephone interview with the Director on 01/29/25 at 1:35pm revealed: -A background check had been competed on Staff A. -He would have the House Manager at the sister facility send a copy of Staff A's completed background check. Requests for Staff A's completed background check on 01/28/25 and 01/29/25 were not provided by the survey exit date. Based on interviews it was determined Staff A was unable to be interviewed.	{C 147}		

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{C 147}	Continued From page 15 Attempted telephone interview with the Administrator on 01/30/25 at 2:57pm was unsuccessful.	{C 147}		
{C 148}	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 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: 1. Review of Staff A's personnel record revealed: -There was no signed job description or hire date. -There was no documentation Staff A had an examination and screening for the presence of controlled substances available. Telephone interview with the House Manager at the sister facility on 01/29/25 at 1:21pm revealed: -Staff A worked at multiple sister facilities. -Staff A had a drug screen completed upon hire. -She could not find a copy of Staff A's drug screen.	{C 148}		

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{C 148}	Continued From page 16 Telephone interview with the Director on 01/29/25 at 1:35pm revealed: -He was responsible for making sure the personnel records were complete. -Staff A had a drug screen completed when she was hired. -He would have the House Manager at the sister facility send a copy of Staff A's drug screen. Requests for Staff A's drug screen results on 01/28/25 and 01/29/25 were not provided by the survey exit date. Based on interviews it was determined Staff A was unable to be interviewed. Attempted telephone interview with the Administrator on 01/30/25 at 2:57pm was unsuccessful. 2. Review of Staff B's personnel record revealed: -Staff B was hired as the House Manager on 01/03/21. -There was no documentation Staff B had an examination and screening for the presence of controlled substances available. Telephone interview with Staff B on 01/28/25 at 3:50pm revealed he had a drug screen on 01/25/25; he would get a copy of the results. Telephone interview with the House Manager at the sister facility on 01/29/25 at 1:21pm revealed: -Staff B worked at sister facilities too. -Staff B "just" had a drug screen. -She could not find a copy of Staff B's drug screen Telephone interview with the Director on 01/29/25	{C 148}		

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{C 148}	Continued From page 17	{C 148}		

at 1:35pm revealed:
-He was responsible for making sure the personnel records were complete.
-Staff B had a drug screen recently and there was an older drug screen in Staff B's personnel record too.
-He would have the House Manager at the sister facility send a copy of Staff B's drug screen.

Requests for Staff B's drug screen results on 01/28/25 and 01/29/25 were not provided by the survey exit date.

Attempted telephone interview with the Administrator on 01/30/25 at 2:57pm was unsuccessful.

3. Review of Staff C's personnel record revealed:
-Staff C was hired as the Supervisor-in-Charge (SIC) on 07/08/96
-There was no documentation Staff C had an examination and screening for the presence of controlled substances available.

Interview with Staff C on 01/18/25 at 3:38pm revealed:
-He had a drug screen at the sister facility about 3 months ago.
-He did not have a copy of the results, but he thought the House Manager for the sister facility would have a copy.

Telephone interview with the House Manager at the sister facility on 01/29/25 at 1:21pm revealed:
-Staff C worked for the facility and/or sister facilities for a long time.
-Staff C had a drug screen a couple of months ago.
-She could not find a copy of Staff C's drug screen

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{C 148}	Continued From page 18 Telephone interview with the Director on 01/29/25 at 1:35pm revealed: -He was responsible for making sure the personnel records were complete. -Staff C had a drug screen "not long ago." -He would have the House Manager at the sister facility send a copy of Staff C's drug screen. Requests for Staff C's drug screen results on 01/28/25 and 01/29/25 were not provided by the survey exit date. Attempted telephone interview with the Administrator on 01/30/25 at 2:57pm was unsuccessful.	{C 148}		
{C 185}	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601 Mangement and Other Staff (a) A family care home administrator who is approved in accordance with Rule .1501 of this Subchapter shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the facility and for meeting and maintaining the rules of this Subchapter. The	{C 185}		

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{C 185}	Continued From page 19 term "administrator" also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations and record reviews and interviews, the Administrator failed to ensure the overall management, operations, policies, and procedures of the facility were implemented, and maintained in substantial compliance with the rules and statutes to meet and maintain rules of adult care homes related to housekeeping and furnishings, and medication administration. The findings are: Observation of the facility on 01/28/25 at 8:05am revealed 5 residents resided in the facility. Observation of the facility on 01/28/25 between 8:05am-5:50pm revealed the Supervisor-in-Charge (SIC) was the only staff member at the facility. Interview with five residents on 01/28/25 from 8:12am-9:56am revealed: -One resident thought the [named] SIC was the Administrator. -Four residents thought the Director was the Owner/Administrator. -None of the residents had seen or knew who the	{C 185}		

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{C 185}	Continued From page 20	{C 185}		

[named] Administrator was.
-If 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 01/20/25.
-If 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 month.
-He was at the facility with the Administrator in November 2024 and December 2024.
-The 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 2024.
-She had not been to the facility in January 2025 because of a family member's health.
-In December 2024, she went to the facility twice.
-She did not work on anything else while at the facility.
-She went to the facility once in November 2024, after Thanksgiving.
-She was trying to find her notes to see what she did in November 2024.
-She was going to have to go to the facility more often because she thought the Director was going through orders to ensure they were implemented.

Non-compliance was identified in the following rule areas:

1. Based on observations and interviews, the facility failed to be maintained in a clean and

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{C 185}	Continued From page 21	{C 185}		

orderly manner, and free of hazards, related to live and dead bed bugs observed in a resident's bedroom and live and dead roaches observed in the dining room. [Refer to Tag 078, 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings (Type B Violation)].

2. 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). [Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].

3. 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. 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. [Refer to Tag 246, 10A NCAC 13G .0902(b) Health Care(Type B Violation)].

4. Based on observations, interviews, and record reviews, the facility failed to serve supplements as ordered for 1 of 1 sampled resident (#2) who had an order for a nutritional supplement. [Refer to Tag 284, 10A NCAC 13G .0904(e)(4) Nutrition and Food Service (Type B Violation)].

5. Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (A) who administered medications, completed a medication clinical skills checklist, and had documentation of a completing the 5, 10, or

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{C 185}	Continued From page 22 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]. 6. 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. [Refer to Tag 148 10A NCAC 13G .0406(a)(8) Other Staff Qualifications]. 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]. 8. Based on record reviews and interviews, the facility failed to ensure that 1 or 3 sampled staff (A) had a criminal background check completed upon hire. [Refer to Tag 147 10A NCAC 13G .0406(a)(7) Other Staff Qualifications]. 9. Based on interviews, and record reviews, the facility failed to implement physician's orders for 2 of 3 sampled residents (#1 and #2) with orders for weekly weights. [Refer to Tag 249, 10A NCAC 13G .0902(c)(3-4) Health Care]. 10. Based on observations, interviews, and record reviews, the facility failed to ensure at least four fire drills were held annually. [Refer to TAG 100, 10A NCAC 13G .0316(e) Fire Safety and Disaster Plan]. 11. Based on observations, interviews, and record	{C 185}		

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{C 185}	Continued From page 23 reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #3) including a medication used to treat constipation and an antifungal cream (#1); and a medicated shampoo (#3). [Refer to TAG 342, 10A NCAC 13G .1004(j) Medication Administration]. 12. Based on observations, record reviews, and interviews, the facility failed to ensure there were readily retrievable records for controlled substances by documenting the receipt, administration, and disposition for 1 of 1 sampled resident (#1) with an order for a medication used to treat anxiety. [Refer to TAG 367, 10A NCAC 13G .1008(a) Controlled Substances]. _____ The Administrator failed to ensure the overall management, operations, and policies of the facility were implemented by failing to ensure medications were administered as ordered to a resident whose medication was administered daily when the medication should have only been 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 health, safety and well being of the residents, which constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/17/25.	{C 185}		

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C 246	Continued From page 24	C 246		
C 246	10A NCAC 13G .0902(b) Health Care 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. a. Interview with Resident #1 on 01/28/25 at 1:04pm revealed: -He had not had his eye drops in a long time. -He could not "see as good." -His vision was getting "worse and worse." -His vision was blurred. -He did not recall the last time he saw his eye doctor. Telephone interview with Resident #1's Ophthalmologist's assistant on 01/28/25 at 3:03pm revealed: -Dorzolamide-timolol (a combination eye drop medication used to treat glaucoma, a condition	C 246		

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that increases pressure in the eye and can damage vision) was ordered to treat Resident #1's glaucoma.
-Resident #1 was last seen in their office on 02/07/24.
-On 02/07/24, Resident #1's eye pressure was 15 in his right eye and 16 in his left eye.
-Resident #1 was to return to the office to have his eye pressure checked in 6 months.
-When the resident left the office, he would have been told to schedule a follow-up appointment in 6 months.
-A follow-up appointment had not been made for Resident #1.
-A request for a refill on the resident's Dorzolamide-timolol (a combination eye drop medication used to treat glaucoma, a condition that increases pressure in the eye and can damage vision) was requested on 07/05/24 and was sent to the facility's contracted pharmacy.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed:
-Resident #1's Dorzolamide-timolol was filled on 06/03/24 and 07/08/24 for a 38-day supply on each dispensing.
-A refill was received on 01/27/25 and the medication would be delivered to the facility on 01/29/25.
-Dorzolamide-timolol was used to reduce pressure in the eyes.

Observation of Resident #1's medications on hand on 01/28/25 at 9:30am revealed there was no Dorzolamide-timolol available to be administered.

Based on review of medication orders, interview with the pharmacist, and observation of

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medications on hand, revealed Resident #1 did not receive his eye drops as ordered.

Review of an American Academy of Ophthalmology document dated 04/12/22 revealed each person's eye pressure was different, and there was no single correct pressure for everyone. Generally, the range for normal pressure was between 10 and 21 mmHg (mmHg means "millimeters of mercury," a scale used to record eye pressure).

Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed:
-He took Resident #1 to the eye doctor, "not long ago" to get glasses.
-He did not know what kind of eye doctor Resident #1 saw, but it was a full eye exam for eyeglasses.
-He thought the appointment with the eye doctor was 6-7 months ago.
-He took Resident #1 to the same eye doctor's office to check his pressure.
-He could not recall when, but it had been less than a year.
-No one had called to schedule an appointment for a follow-up to have Resident #1's eye pressure checked.
-If he was supposed to make a follow-up appointment, he may have made a mistake not scheduling it.

Telephone interview with Resident #1's primary care provider (PCP) on 01/28/25 at 4:16pm revealed:
-She saw Resident #1 monthly at the facility.
-She recalled Resident #1 having a bulging eye in 2023.
-She did not know Resident #1 had not seen his Ophthalmologist.

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C 246	Continued From page 27 -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. Attempted telephone interview with Resident #1's Ophthalmologist on 01/28/25 at 3:03pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 01/18/25 at 3:38pm. 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. b. Review of Resident #1's PCP's after-visit summary dated 11/05/24, 12/10/24, and 01/17/25 revealed: -Resident #1 was seen for chronic care management. -Please take for labs. Interview with Resident #1 on 01/28/25 at 1:04pm revealed he did not recall having any bloodwork done in a "long time." Telephone interview with Resident #1's PCP on 01/29/25 at 11:59am revealed: -She ordered labs for Resident #1 because the resident had not had lab work in over a year. -She reminded the staff member every month	C 246		

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C 246	Continued From page 28 Resident #1's lab work needed to be done. Telephone interview with Resident #1's PCP on 01/30/25 at 9:53am revealed: -Resident #1's lab work was ordered to monitor the resident's overall health. -Labs were used to ensure medications were effective. -She had ordered an albumin level (used to see if the body was absorbing enough protein) for Resident #1. -She wanted to make sure Resident #1's kidney function was okay. -She wanted to make sure Resident #1's complete blood count (CBC), including hemoglobin, and white blood count were all within normal range. Telephone interview with the House Manager on 01/29/25 at 9:44am revealed: -He knew Resident #1 had an order for lab work. -The PCP had left the paperwork for him to take Resident #1 to the lab to get blood work done. -He had been trying to get Resident #1 to go, but the resident would say he did not want to go when he asked. -Resident #1 was getting older and did not like to leave the facility. -He told the PCP he was going to take Resident #1 to get the lab work completed. -He did not recall if he had told the PCP Resident #1 had refused to go. Telephone interview with the Director on 01/29/25 at 10:32am revealed: -The House Manager was responsible for making sure Resident #1's lab work was obtained. -If there were any problems getting Resident #1's labs, he should have been notified. -He was not aware Resident #1 had refused to go	C 246		

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C 246	Continued From page 29 to the lab. Refer to the interview with the SIC on 01/18/25 at 3:38pm. 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 now. -He could not recall the last time he went to the dentist, but it had been a long time, more than a year. Telephone interview with Resident #2's Dentist on 01/28/25 at 3:31pm revealed: -He was concerned Resident #2 had not been seen by a dentist since 2022. -There were multiple "no-shows" and rescheduled appointments in 2022, 2023, and 2024. -Cleaning was important in oral care and he was concerned the resident had not been seen for dental care. -The resident could have some issues with gingivitis (an inflammation of the gums caused by the accumulation of plaque, a sticky film of bacteria that builds up on the teeth, from poor oral hygiene). -The resident needed to be seen every 6 months for routine dental care. -He ordered Prevident 5000 toothpaste for Resident #1 because the resident had a history of cavities and additional fluoride could be proactive	C 246		

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C 246	Continued From page 30 in preventing additional 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 cavities. -Resident #1's Prevident toothpaste was filled on 07/23/24 and 08/18/24 for a 30-day supply for each dispensing. -Resident #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. Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed: -He drove to Resident #1's dentist's office about one week ago to make an appointment for Resident #1, but the dentist's office was closed. -He did not know anything about missed appointments in 2022 because he had only been the House Manager for "about" two years. -Resident #1 had not had any complaints or problems with his teeth. Telephone interview with Resident #1's PCP on 01/28/25 at 4:16pm revealed: -Resident #1's teeth were not in the best condition, and he needed to be seen by a dentist.	C 246		

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C 246	Continued From page 31 -She was not aware Resident #1 had not been seen by the dentist. Telephone interview with the Director on 01/29/25 at 10:32am revealed: -He was with the House Manager recently when they went by Resident #1's dentist's office, and it was closed. -On 01/29/25, an appointment was made for Resident #1 for February 2025. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -She was told the SIC had called Resident #1's dentist office 3 times and the dentist had not returned his call; two days ago. -If the dentist did not return the staff members' call, she expected them to locate another dentist for the resident. Refer to the interview with the SIC on 01/18/25 at 3:38pm. 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. _____ Interview with the SIC on 01/18/25 at 3:38pm revealed he did not have anything to do with resident appointments, because that was the House Manager's responsibility. Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed:	C 246		

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C 246	Continued From page 32 -He was responsible for overseeing the normal activity of the facility. -He took residents to appointments, and he scheduled appointments. -He occasionally worked as the SIC at the facility, but it was usually only for a few hours. Telephone interview with the Director on 01/29/25 at 10:32am revealed: -The House Manager was responsible for ensuring all follow-up appointments were made. -The House Manager was responsible for taking the residents to their appointments. -He was concerned appointments had been missed and would be putting systems in place to make sure it did not happen again. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -The Director was responsible for making sure appointments were made and the residents went to the appointments. -She did not know the residents were missing appointments. -The Director was not going over the orders and making sure they were being done. -She expected the staff to go over the orders better than they were doing and follow up as needed. _____ The facility failed to ensure referrals and follow up for a resident (#1) who had not been seen by his Ophthalmologist to have his eye pressure checked in over six months and had not received his eye drops used to lower pressure. The resident had a diagnosis of gingivitis and had not been seen by a dentist since 2022 and had not used the fluoride toothpaste the dentist had ordered for preventive care. The PCP requested lab work be completed multiple times to monitor	C 246		

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C 246	Continued From page 33 the resident's overall health and the resident had not had any bloodwork completed. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/31/25 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 17, 2025.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to implement physician's orders for 2 of 3 sampled residents (#1 and #2) with orders for weekly weights. 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	C 249		

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the left eye.

Review of Resident #2's primary care provider's (PCP) after-visit summary dated 07/09/24 revealed Resident #2 weighed 165 pounds (lb).

Review of Resident #2's PCP after-visit summary dated 08/07/24 revealed:
-Resident #2 weighed 152.8 lbs.
-Resident #2 had a 13 lb weight loss.
-There was an order to weigh weekly, record, and notify the PCP for a weight change greater than 5 lbs.

Review of Resident #2's PCP after-visit summaries revealed:
-On 09/06/24, Resident #2 weighed 149 lbs; a 3 lb weight loss.
-On 10/06/24, Resident #2 weighed 147 lbs.
-On 12/10/24, Resident #2 weighed 145.2 lbs.
-On 01/17/25, Resident #2 weighed 146.6 lbs.

Review of Resident #2's November 2024, December 2024, and January 2025 from 01/01/25-01/28/25 medication administration records (MAR) revealed:
-There was an entry for monthly weights.
-There were no weights documented on the front or back of the MARs.

Interview with Resident #2 on 01/28/25 at 1:25pm revealed:
-He was weighed when the doctor was at the facility.
-He was not weighed weekly by staff at the facility.
-He had lost "quite" a bit of weight.

Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed he did not know

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Resident #2 had an order for weekly weights.

Telephone interview with Resident #2's PCP on 01/28/25 at 4:16pm revealed:
-Resident #2 had weight loss and she requested the resident be weighed weekly so she could monitor any ongoing weight loss.
-She was concerned that the resident could have ongoing weight loss, and she had not been notified.
-She expected staff to follow the order as written.

Refer to the interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 11:28am.

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 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.

2. Review of Resident #1's current FL-2 dated 05/03/24 revealed diagnoses included hypertension, osteoarthritis, Parkinson's, anemia, gastroesophageal reflux disease, sleep apnea, chronic obstructive pulmonary disease, vitamin D deficiency, gingivitis, and chronic paranoid schizophrenia.

Review of Resident #1's primary care provider's (PCP) after-visit summary dated 12/10/24 revealed Resident #1 weighed 160.4 pounds (lbs.).

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C 249	Continued From page 36 Review of Resident #1's PCP after-visit summary dated 01/17/25 revealed: -Resident #1 weighed 155 lbs. -Resident #1 had a 5 lb weight loss. -There was an order to weigh Resident #1 weekly, record, and notify the PCP for a weight change greater than 3 lbs. Review of Resident #1's January 2025 medication administration record (MAR) from 01/01/25-01/28/25 revealed: -There was an entry for monthly weights. -There were no weights documented on the front or back of the MAR. Interview with Resident #1 on 01/28/25 at 1:25pm revealed: -He was weighed when the doctor was at the facility. -He was not weighed weekly by staff at the facility. -He did not know if he had lost any weight or not. Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed he did not know Resident #1 had an order for weekly weights. Telephone interview with Resident #1's PCP on 01/28/25 at 4:16pm revealed: -Resident #1 had weight loss and she requested the resident be weighed weekly so she could monitor any ongoing weight loss. -She was concerned that the resident could have ongoing weight loss. -She expected staff to follow the order as written. Refer to the interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 11:28am.	C 249		

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C 249	Continued From page 37 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 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. _____ Interview with the SIC on 01/28/25 at 11:28am revealed: -Weights were documented on the back of the MAR. -He had not weighed any residents since he started working at the facility on 01/20/25. -The facility did not have scales that worked. -The facility's contracted PCP weighed the residents during her monthly visits. -None of the residents had an order for weekly weights. -All the residents had an order for monthly weights. Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed: -The facility staff did not do weekly or monthly weights. -The facility's PCP weighed the residents every four weeks. Telephone interview with the House Manager on 01/29/25 at 9:44am revealed: -Whoever was working at the facility when the PCP made her monthly visits was responsible for reading the notes and making sure any orders were implemented.	C 249		

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C 249	Continued From page 38 -He had not been going behind the staff to make sure the staff were doing what they were supposed to do. Telephone interview with the Director on 01/29/25 at 10:32am revealed: -He did not know there were orders for weekly weights. -The staff should have called him if the facility needed scales. -The SIC that was working the day the PCP wrote the order, should have written the order on the MAR for weekly weights. -The House Manager should go behind the SIC and make sure orders were implemented. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -The SIC was responsible for following all new orders. -The Director was responsible for making sure all new orders had been implemented. -She did not know the residents had orders for weekly weights that were not being done. -She was concerned the residents were not weighed as ordered. -She expected the SIC to read over the orders thoroughly. -The Director was responsible for making sure the facility had scales to do the weekly weights.	C 249		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care	C 257		

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C 257	Continued From page 39 Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all food items were protected from contamination related to observations of roaches, both living and dead, on the kitchen counters and dead roaches in the refrigerator. The findings are: Review of the facility's Environmental Health Inspection report dated 01/06/25 revealed: -There were 9 total demerits. -Demerits included floors and carpet in good repair, walls, ceilings, and attachments in good repair, handwashing provided, and pest presence. -Two live roaches were observed in the kitchen and dead roaches were observed in the cabinets in the kitchen as well. -Pests should not be present in a residential care facility. -Be sure to remove dead pests to prevent	C 257		

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C 257	Continued From page 40 harborage. Observation of the kitchen on 01/28/25 at 8:33am revealed: -There was a live cockroach on the kitchen counter. -There were 2 live roaches on the wall between the kitchen counter and the wall cabinets. Observation of the refrigerator on 01/28/25 at 8:34am revealed: -There were multiple dead roaches in the refrigerator. -There was a dead cockroach on the door gasket. Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 3:26pm revealed: -He had seen roaches in the kitchen. -He had not told the Director he had seen live roaches because he assumed the Director had seen them. Telephone interview with a representative from the facility's contracted pest control company on 01/18/25 at 12:44pm revealed: -The facility had not been treated for roaches by their company. -The facility had not requested pest treatment. -The facility could be treated for roaches, but the staff would need to request pest treatment. Telephone interview with the county Environmental Health Specialist on 01/29/25 at 8:25am revealed: -She saw live and dead roaches at the facility on 01/06/25. -Roaches carried diseases. -Dead roaches needed to be cleaned up because live roaches eat dead ones. -Not cleaning up dead pests was considered	C 257		

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harborage (in pest control, harborage referred to the locations and conditions where pests could live, thrive, and reproduce).
-Roaches would keep "coming around" if not cleaned up.

Telephone interview with the House Manager on 01/29/25 at 9:44am revealed:
-He had seen roaches at the facility, "now and then."
-The staff had been treating the roaches using a [named] spray that was safe to use around the residents.
-He could not make the decision to use a pest control company.
-The staff working usually sprayed at night.

Telephone interview with the Director on 01/29/25 at 10:32am revealed:
-The staff had been treating the facility for roaches.
-He used a [named] safe spray once a month to treat the roaches.
-He thought the spray was working because the roaches had been "bad' but were getting better.
-He had not called the pest control company to treat the roaches.
-He had not read the Environmental Health report dated 01/06/25.
-Cleaning the facility was an ongoing process to clean up dead pests.
-If the SIC did not clean up the dead roaches on 01/28/25, it was probably because he was "nervous" because the surveyor was in the facility.

Telephone interview with the facility's contracted primary care provider (PCP) on 01/29/25 at 11:59am revealed:
-She had seen live roaches at the facility.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JONES FAMILY HOME	2122 OVERLAND DRIVE DURHAM, NC 27704

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C 257	Continued From page 42 -Roaches carried disease and were not sanitary. -She thought the facility needed to be professionally exterminated. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -The staff had not notified her of the presence of roaches. -The staff should have let her know they had seen roaches. Telephone interview with the Administrator on 01/30/25 at 9:57am revealed she expected the SIC to clean up dead roaches daily, as often as they saw them. Telephone interview with the Supervisor-in-Charge on 01/29/25 at 11:38am revealed: -He cleaned the facility every day. -He had not done pest control at the facility. -He swept the facility every morning and every evening. -If he saw dead pests he swept them up. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -The Director needed to have a pest company come out and treat the facility. -The facility needed professional treatment. -She was concerned that the facility had pests because it was not good for the residents' health. According to the United States Environmental Protection Agency (EPA) publication dated 10/28/24 revealed roaches and their droppings may trigger an asthma attack. Their feces, saliva, eggs, outer covering, or cuticles left behind on surfaces contained substances that were allergenic to humans, especially those with	C 257		

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C 257	Continued From page 43 asthma or other respiratory conditions. Within and on the surface of their bodies, roaches carried bacteria that could cause salmonella, staphylococcus, and streptococcus if deposited in food.	C 257		
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to serve supplements as ordered for 1 of 1 sampled resident (#2) who had an order for a nutritional supplement. The findings are: 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. Review of Resident #2's primary care provider's (PCP) after-visit summary dated 07/09/24 revealed Resident #2 weighed 165 pounds (lb). Review of Resident #2's PCP after-visit summary	C 284		

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dated 08/07/24 revealed:
-Resident #2 weighed 152.8 lbs.
-Resident #2 had a 13 lb weight loss.
-There was an order to weigh weekly, record, and notify the PCP if greater than 5 lbs.
-There was an order for a nutritional supplement twice daily.

Review of Resident #2's PCP after-visit summary dated 09/06/24 revealed:
-Resident #2 weighed 149 lbs; a 3 lb weight loss.
-A 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 147 lbs.
-On 12/10/24, Resident #2 weighed 145.2 lbs.
-On 01/17/25, Resident #2 weighed 146.6 lbs.

Review of Resident #2's November 2024, December 2024, and January 2025 from 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.

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 often.
-He 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.

Observation of the refrigerator on 01/18/25 at 11:30am revealed there were 3 bottles of a

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nutritional supplement in the bottom drawer of the refrigerator.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed the pharmacy had not dispensed a nutritional supplement for Resident #2; it was usually dispensed from a medical supply company.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/28/25 at 5:11pm revealed if Resident #2's order for a nutritional supplement was received, the order would have been entered into the MAR so staff could document when the nutritional supplement was given to the resident.

Telephone interview with a representative from a medical supply company on 01/29/25 at 11:17 revealed:
-Resident #2 had been supplied with a nutritional supplement from their company in August 2024 and September 2024.
-Three cases of a [named] nutritional supplement had been sent to the facility for Resident #2; each case contained 24 individually packaged supplements.
-They had not sent any additional nutritional supplements to Resident #2 due to not being reimbursed for the cases already sent.
-A staff member at the facility was notified that Resident #2's nutritional supplements would not be sent due to not getting paid.

Interview with Resident #2 on 01/28/25 at 1:25pm revealed:
-He had not been given a nutritional supplement to drink in a couple of months.
-He had lost "quite a bit of weight."

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C 284	Continued From page 46 Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed: -Resident #2 had an order for a nutritional supplement. -He did not recall the order details, but the order should be on the resident's MAR. -If Resident #2's nutritional supplement was not documented on the MAR, it was because the staff forgot to document it. Telephone interview with Resident #2's PCP on 01/28/25 at 4:16pm revealed: -She ordered a nutritional supplement for Resident #2 because of weight loss and overall health. -The order was for Resident #2 to be served a nutritional supplement twice a day. -She was not aware he was not being served the nutritional supplement. -She wished the facility staff would have called her to let her know the nutritional supplement was not being delivered. -She was concerned he was not receiving the nutritional supplement because of his weight loss. Telephone interview with Resident #2's primary care provider (PCP) on 01/29/25 at 11:59am revealed if Resident #2 had received the nutritional supplement as ordered, it would have decreased the amount of weight the resident had lost. Telephone interview with the Director on 01/29/25 at 10:32am revealed: -He thought Resident #2 got a nutritional supplement twice a day. -He had given Resident #2 a nutritional supplement when he worked. -He did not document when he gave Resident #2	C 284		

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C 284	Continued From page 47 a nutritional supplement. -Resident #2 knew he was supposed to get the nutritional supplement and usually asked for it. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -Orders for a nutritional supplement should be faxed to the pharmacy, entered on the MAR, and documented as administered. -If Resident #2's nutritional supplement was not delivered, she expected the staff to call and see why it was not delivered and let the PCP know it was not delivered. _____ The facility failed to serve Resident #2 a nutritional supplement twice daily as ordered after the resident had a 13 lb weight loss and continued to lose weight. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/11/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 17, 2025.	C 284		
{C 330}	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and	{C 330}		

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{C 330}	Continued From page 48 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION 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. a. Review of Resident #2's oncology after-visit summary dated 11/15/24 revealed an order for Dexamethasone (a steroid used to treat inflammation) 4mg take 2 tablets for 2 days following chemotherapy treatments; start taking 11/20/24. Review of Resident #2's oncology after visit summaries revealed the resident received chemotherapy on 11/21/24, 12/12/24, 01/02/25, and 01/23/25. Review of Resident #2's November 2024 medication administration record (MAR) from 11/20/24-11/30/24 revealed: -There was an entry for Dexamethasone 4mg take two tablets every morning for two days after chemotherapy with a scheduled administration	{C 330}		

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{C 330}	Continued From page 49	{C 330}		

time of 8:00am.
-There was documentation Dexamethasone was administered at 8:00am on 11/21/24 and 11/22/24.

Review of Resident #2's December 2024 MAR revealed:
-There was an entry for Dexamethasone 4mg take two tablets every morning for two days after chemotherapy with a scheduled administration time of 8:00am.
-There was documentation Dexamethasone was administered at 8:00am on 12/01/24-12/24/24 at 8:00am.
-The initials were marked out from 12/01/24-12/12/24, and 12/15/24-12/24/24 and documented as an error.
-The remaining initials were for 12/13/24 and 12/14/24.

Review of Resident #2's January 2025 MAR from 01/01/25-01/28/25 revealed:
-There was an entry for Dexamethasone 4mg take two tablets every morning for two days after chemotherapy with a scheduled administration time of 8:00am.
-There was documentation Dexamethasone was administered at 8:00am on 01/01/25-01/27/25.
-There was an exception documented for 01/28/25 as the pill had been dropped on the floor and was not administered.

Observation of Resident #2 on 01/18/25 at 10:28am revealed:
-Resident #1 approached the SIC and stated, "Something is wrong with me; I must have gotten my medication wrong."
-"My heart is racing, and I feel antsy and nervous."
-Something is "not right."

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{C 330}	Continued From page 50 -The SIC told him to lie down for a little while to see if he felt better. Second observation of Resident #2 on 01/18/25 at 11:17am revealed: -Resident #2 told the 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 Resident #2's medication on hand on 01/28/25 at 11:19am revealed : -Resident #2's medications were in a multidose plastic packet. -There were no Dexamethasone tablets in the multidose plastic packet. -There was a punch card of Dexamethasone 4mg with the directions to take two tablets every morning for 2 days after chemotherapy. -Thirty tablets were dispensed on 11/15/24; 18 tablets were remaining on the punch card. Based on MAR reviews, interviews, and observations of medication on hand, it could not be determined when Resident #2's Dexamethasone was administered. There were 18 tablets of Dexamethasone on the punch card and there should have been 14 tablets remaining. Interview with Resident #2 on 01/28/25 at 1:25pm revealed: -He had a round of chemotherapy last Thursday, 01/23/25. -He had four rounds of chemotherapy, and each round was three weeks apart. -He felt terrible today, 01/28/25, he had never felt like he did today. -"I am all nervous, like on the inside"; it was hard to explain.	{C 330}		

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{C 330}	Continued From page 51 Interview with the SIC on 01/28/25 at 1:45pm revealed: -He had administered Resident #2's Dexamethasone every day since he started working at the facility, 01/20/25. -He did not know when Resident #2's last chemotherapy treatment was. -He administered Dexamethasone tablet from the punch card, "every day". -He gave one tablet of Dexamethasone every day because he did not know what day Resident #2 had received chemotherapy and did not want the medication to get out of the resident's system. -If he had known what day Resident #2 had received chemotherapy, he would have administered 2 tablets of Dexamethasone for the number of days ordered and then stopped. -He had not administered Resident #2's Dexamethasone today, 01/28/25. -He documented on the MAR he did not administer Resident #2's Dexamethasone today, 01/28/25, because he had dropped the tablet when he was administering Resident #2's morning medications. -The tablet he dropped was out of Resident #2's multidose packet. Observation on 01/28/25 at 1:45pm revealed: -Dexamethasone was not in the multidose packet. -The SIC pointed to a tablet in the packet as the tablet he dropped. -The tablet was identified as an Aspirin 81mg (used to prevent heart attack or stroke). -The SIC showed the surveyor Resident #2's punch card for Dexamethasone. Interview with the SIC on 01/28/25 at 1:45pm revealed he "just" documented the wrong tablet	{C 330}		

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{C 330}	Continued From page 52 on the MAR that he had dropped. Second interview with the SIC on 01/28/25 at 1:50pm revealed: -He did not administer Resident #2's Dexamethasone today, 01/28/25. -He did not answer why he stated earlier he had administered all of his medications except the tablet he had dropped, which was an aspirin, but now he was saying he did not give Dexamethasone today. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/28/25 at 2:03pm revealed: -Dexamethasone was a steroid medication. -If Resident #2's Dexamethasone was administered more often than it was ordered, the resident could experience increased nervousness, as well as a fluid buildup. -If Resident #2 had been administered Dexamethasone 7 days in a row, the resident could have increased nervousness and could feel "jittery". Telephone interview with the oncology triage nurse on 01/28/25 at 3:27pm revealed: -Resident #2 should take Dexamethasone for 2 days after his chemotherapy treatments. -Taking the Dexamethasone for more than 2 days would cause increased blood sugar. -It could also cause nervous energy. -The resident might have a higher heart rate. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -She had seen the order for Resident #2's Dexamethasone to be administered 2 tablets for 2 days after chemotherapy. -She expected staff to block off the order on the	{C 330}		

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{C 330}	Continued From page 53 MAR so the medication was not administered when it was not supposed to. 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 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. 2. 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. -There was documentation for medication to see the medication administration record (MAR). a. Review of Resident #1's May 2024 MAR revealed an entry for Dorzolamide-timolol (a combination eye drop medication used to treat glaucoma, a condition that increases pressure in the eye and can damage vision) instill one drop in each eye twice daily. Review of Resident #1's November 2024 MAR revealed: -There was an entry for Dorzolamide-timolol instill one drop in each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Dorzolamide-timolol was administered twice daily at 8:00am and 8:00pm from 11/01/24-11/30/24.	{C 330}		

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{C 330}	Continued From page 54 Review of Resident #1's December 2024 MAR revealed: -There was an entry for Dorzolamide-timolol instill one drop in each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Dorzolamide-timolol was administered twice daily at 8:00am and 8:00pm from 12/01/24-12/31/24. Review of Resident #1's January 2025 MAR from 01/01/25-01/28/25 revealed: -There was an entry for Dorzolamide-timolol instill one drop in each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Dorzolamide-timolol was administered twice daily at 8:00am and 8:00pm from 01/01/25-01/28/25. Observation of Resident #1's medications on hand on 01/28/25 at 9:30am revealed there was no Dorzolamide-timolol available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed: -Resident #1's Dorzolamide-timolol was filled on 06/03/24 and 07/08/24 for a 38-day supply on each dispensing. -A refill was received on 01/27/25 and the medication would be delivered to the facility on 01/29/25. -Dorzolamide-timolol was used to reduce pressure in the eyes. Interview with Resident #1 on 01/28/25 at 1:04pm revealed: -He had not had his eye drops in a long time. -He could not "see as good."	{C 330}		

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-His vision was getting "worse and worse."
-His vision was blurred.
-His 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.
-A new bottle was being delivered tomorrow, 01/28/25.
-He did not know why Resident #1 still had Dorzolamide-timolol from the July 2024 refill that he had used to administer to the resident.
-He could not say what anyone else had done, but if he documented his initials that meant the medication was administered.

Second review of Resident #1's January 2025 MAR from 01/01/25-01/28/25 revealed there were check marks and/or an X mark on multiple medications; there was no mark beside Resident #1's Dorzolamide-timolol eye drops.

Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed if Resident #1's Dorzolamide-timolol had been documented as administered she would not have known he was not getting his eye drops as ordered.

Telephone interview with Resident #1's primary

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care provider (PCP) on 01/28/25 at 4:16pm revealed:
-Resident #1's Dorzolamide-timolol eye drops should be administered as ordered.
-The last time she wrote a refill for Resident #1's Dorzolamide-timolol eye drops was in 2023.

Attempted telephone interview with Resident #1's Ophthalmologist on 01/28/25 at 3:03pm 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 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.

b. Review of Resident #1's May 2024 MAR revealed there was an entry for Prevident 5000 plus (a prescription fluoride toothpaste), brush for two minutes twice daily, and then spit out.

Review of Resident #1's November 2024 MAR revealed:
-There was an entry for Prevident 5000 plus, brush for two minutes twice daily and then spit out with a scheduled administration time of 8:00am and 8:00pm.
- There was documentation Prevident 5000 was administered twice daily from 11/01/24-11/30/24.

Review of Resident #1's December 2024 MAR revealed:
-There was an entry for Prevident 5000 plus,

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brush for two minutes twice daily and then spit out with a scheduled administration time of 8:00am and 8:00pm.
- There was documentation Prevident 5000 was administered twice daily from 12/01/24-12/31/24.

Review of Resident #1's January 2025 MAR from 01/01/25-01/28/25 revealed:
-There was an entry for Prevident 5000 plus, brush for two minutes twice daily and then spit out with a scheduled administration time of 8:00am and 8:00pm.
- There was documentation Prevident 5000 was administered twice daily from 01/01/25-01/28/25.

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 cavities.
-Resident #1's Prevident toothpaste was filled on 07/23/24 and 08/18/24 for a 30-day supply for each dispensing.
-Resident #2's Prevident toothpaste was refilled on 01/27/25 and would be delivered to the facility on 01/29/25.

Telephone interview with the office assistant from Resident #1's dentist office on 01/28/25 at 2:39pm revealed the pharmacy had requested a refill on Resident #1's toothpaste on 01/27/25.

Interview with Resident #1 on 01/28/25 at 1:04pm revealed:
-He used to use toothpaste his dentist ordered.

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-He had not had "that" toothpaste in a long time.
-He was told his toothpaste was going to be delivered tomorrow, 01/29/25.
-His teeth were "okay" for now.

Interview with the SIC on 01/28/25 at 1:06pm revealed:
-He looked at Resident #1's MARs and compared it 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."
-Resident #1 had "just finished up" his tube of Prevident was why there was none on hand.
-Resident #1 had been using the Prevident toothpaste every day as ordered.
-A new tube of Prevident was ordered, he did not recall when it was ordered.
-He did not know why Resident #1 still had Prevident toothpaste from the August 2024 refill for him to administer to the resident.
-He could not say what anyone else had done, but if he documented his initials that meant the medication was administered.

Second review of Resident #1's January 2025 MAR from 01/01/25-01/28/25 revealed there were check marks and/or an X mark on multiple medications; there was no mark beside Resident #1's Prevident toothpaste.

Telephone interview with Resident #1's Dentist on 01/28/25 at 3:31pm revealed:
-He ordered Prevident 5000 toothpaste for Resident #1 because the resident had a history of cavities and additional fluoride could be proactive in preventing additional cavities.
-He expected the toothpaste to be used as ordered.

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{C 330}	Continued From page 59 Telephone interview with the Administrator on 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. Telephone interview with Resident #1's PCP on 01/28/25 at 4:16pm revealed: -Resident #1's teeth were not in the best condition. -She expected Resident #1's Prevident toothpaste to be used as ordered. 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 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. 3. Review of Resident #3's FL-2 dated 01/24/25 revealed: -Diagnoses included heart failure, hypertension and implantable cardioverter defibrillator. -There was an order for Prednisone (a steroid used to treat inflammation) 20mg, take 2 tablets every 4 days. Review of Resident #3's January 2025 medication administration record (MAR) from 01/01/25-01/28/25 revealed: -There was an entry for Prednisone 20mg take two tablets for 4 days with a scheduled administration time of 8:00am.	{C 330}		

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{C 330}	Continued From page 60 -There was documentation Prednisone 20mg was administered daily from 01/01/25-01/28/25. Observation of Resident #3's medications on hand on 01/28/25 at 10:41am revealed there was no Prednisone 20mg available to be administered. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed: -The only Prednisone order in their system for Resident #3 was Prednisone 20mg, take two tablets daily for 4 days; the order was received on 11/23/24. -Eight tablets of Prednisone 20mg were dispensed and had not been refilled. -The pharmacy had not received a copy of Resident #3's FL-2 dated 01/24/25. -If she had received a copy of the FL-2 all medications listed on the FL-2 would have been filled. -It sounded like Resident #3's Prednisone 20mg should be administered every four days based on the FL-2. -Prednisone would have been filled as ordered on the FL-2. Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 2:01pm revealed he did not do anything with Resident #3's FL-2, the House Manager was responsible for FL-2s. Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed: -He could not recall who completed Resident #3's FL-2, either him or the primary care provider (PCP), but he thought it was the PCP. -He had taken Resident #3 to the PCP and when he returned to the facility he gave the FL-2 to the	{C 330}		

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{C 330}	Continued From page 61 SIC working. -The SIC was responsible for comparing the FL-2 to the medications on hand and the MAR and if anything did not match, the SIC should have contacted the PCP. -He did not know if the new FL-2 matched the medications on hand and/or the MAR. -He recalled the PCP stating he was starting Resident #3 on a new medication, but he did not know what the medication was. -The new medication was going to be sent to the pharmacy; the PCP confirmed the name of the pharmacy to send the order. Telephone interview with the Director on 01/29/25 at 10:32am revealed the House Manager was responsible for reviewing the FL-2 and making sure the MAR matched. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -New FL-2s should be faxed to the pharmacy. -She was not aware Resident #3 had an order for Prednisone on his FL-2 that had not been implemented. -She 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 telephone interview with the Director on 01/29/25 at 10:32am.	{C 330}		

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{C 330}	Continued From page 62 Refer to the telephone interview with the Administrator on 01/29/25 at 12:24pm. _____ Telephone interview with the House Manager on 01/28/25 at 3:50pm revealed he did not know anything about the medication administration process; the Director would have to answer that question. Telephone interview with the House Manager on 01/29/25 at 9:44am revealed: -At the beginning of the month, the medications on hand were compared to the residents' MAR to make sure they matched. -He did not do MAR audits. Telephone interview with the Director on 01/29/25 at 10:32am revealed: -Staff should compare the MAR with the medications on hand. -Staff should look at the medications and make sure they matched the MAR before administering the medication to the residents. -He did not recall what medications he had administered to the residents because he went to so many different facilities and worked when he was needed. -He had serious concerns that the residents' medications had not been administered as ordered. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -She expected the staff to administer medications as ordered. -She expected the staff to compare the medication on hand to the MAR administer the medication and then document.	{C 330}		

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{C 330}	Continued From page 63 -She reviewed the residents' MARs when she was at the facility in December 2024. -She did not look at the medications on hand to make sure the medications ordered were in the facility. _____ The facility failed to administer medications as ordered for 3 of 3 sampled residents including administering a steroid medication daily when the medication was only to be administered for two days and the resident was feeling jittery and nervous which could be a side effect of daily administration of the medication (#2); and a resident who had a diagnosis of glaucoma and had not been administered his eye drops correctly for more than 5 months which could increase the resident's risk of increased eye pressure (#1); and a resident who had an order for a steroid and the medication had not been filled (#3). This failure was detrimental to the health and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/31/25 for this violation. THE CORRECTION DATE FOR TH TYPE B VIOLATION SHALL NOT EXCEED MARCH 17, 2025.	{C 330}		
{C 342}	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name;	{C 342}		

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{C 342}	Continued From page 64 (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 2 of 3 sampled residents (#1, #3) including a medication used to treat constipation and an antifungal cream (#1); and a medicated shampoo (#3). The findings are: 1. 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. -There was documentation for medication to see the medication administration record (MAR). a. Review of Resident #1's May 2024 MAR	{C 342}		

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{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.

Review of Resident #1's November 2024 MAR revealed:
-There was an entry for Miralax one capful once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 11/01/24-11/30/24.

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 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 12/01/24-12/31/24.

Review of Resident #1's January 2025 MAR from 01/01/25-01/28/25 revealed:
-There was an entry for Miralax one capful once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 01/01/25-01/28/25.

Observation of Resident #1's medications on hand on 01/28/25 at 9:30am revealed a bottle of Miralax with a dispensed date of 06/24/24; the bottle was more than three-fourths full.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed Resident #1's Miralax was filled on 05/06/24 and 06/24/24 for a

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{C 342}	Continued From page 66 30-day supply. Interview with Resident #3 on 01/28/25 at 5:08pm revealed: -He did not know if there was medication in his beverage in the morning. -He had not had any problems with his bowels since the summer of 2024. Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 1:06pm revealed: -He administered Resident #1's Miralax today, 01/28/25. -He had administered Resident #1's Miralax every day he worked. -He did not know why the Miralax bottle was still full. -Maybe someone had used another resident's Miralax. -He could not say what anyone else had done, but if he documented his initials that meant the medication was administered. 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 telephone interview with the House Manager on 01/29/25 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. b. Review of Resident #1's May 2024 MAR revealed an entry for Clotrimazole 1% topical cream (an antifungal cream) apply to toes twice daily.	{C 342}		

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{C 342}	Continued From page 67 Review of Resident #1's November 2024 MAR revealed: -There was an entry for Clotrimazole 1% topical cream apply to toes twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Clotrimazole 1% topical cream was applied daily at 8:00am and 8:00pm from 11/01/24-11/30/24. Review of Resident #1's December 2024 MAR revealed: -There was an entry for Clotrimazole 1% topical cream apply to toes twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Clotrimazole 1% topical cream was applied daily at 8:00am and 8:00pm from 12/01/24-12/31/24. Review of Resident #1's January 2025 MAR from 01/01/25-01/28/25 revealed: -There was an entry for Clotrimazole 1% topical cream apply to toes twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Clotrimazole 1% topical cream was applied daily at 8:00am and 8:00pm from 01/01/25-01/28/25. Observation of Resident #1's medications on hand on 01/28/25 at 9:30am revealed a tube of Clotrimazole 1% cream with a dispensed date of 11/14/23; the tube was more than 95% full. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed: -Resident #1's Clotrimazole cream was filled on 11/14/23 and 06/24/24 for a 30-day supply. -Clotrimazole cream was usually used for short-term use, but they had not received a	{C 342}		

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{C 342}	Continued From page 68 discontinued order, so it continued to be on the MAR. Interview with Resident #3 on 01/28/25 at 5:08pm revealed: -The SIC did not apply cream to his feet every day. -He did not have any problems with his feet that needed cream. Interview with the SIC on 01/28/25 at 1:06pm revealed: -He applied cream to Resident #1's toes twice a day. -He applied cream to Resident #1's toes today, 01/28/25. -It only took a small amount to apply to Resident #1's toes. -He could not say what anyone else had done, but if he documented his initials that meant the medication was administered. 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 telephone interview with the House Manager on 01/29/25 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. 2. Review of Resident #3's FL-2 dated 01/24/25 revealed: -Diagnoses included heart failure, hypertension, and implantable cardioverter defibrillator. -There was an order for Ketoconazole 2%	{C 342}		

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{C 342}	Continued From page 69 shampoo (used to treat fungal infections of the scalp) twice weekly. Review of Resident #3's January 2025 MAR from 01/24/25-01/28/25 revealed: -There was an entry for Ketoconazole 2% shampoo apply twice weekly with a scheduled administration time of 8:00am. -There was documentation Ketoconazole 2% shampoo was applied on 01/27/25. Observation of Resident #3's medications on hand on 01/28/25 at 10:41am revealed there was no Ketoconazole 2% shampoo available to be applied. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/28/25 at 11:58am revealed: -Resident #3's Ketoconazole shampoo was filled on 03/26/24; there was no other dispensing. -The order was for Ketoconazole to be applied twice weekly. -It depended on how much was used each time as to how long it would last but it was only a four-ounce bottle so would only last approximately 30 days. Interview with Resident #3 on 01/28/25 at 5:10pm revealed he had a "spot" on his head but it had been cleared up "for a while." Interview with the Supervisor-in-Charge (SIC) on 01/28/25 at 2:01pm revealed: -Resident #3's infection had cleared up and he was going to get an order to discontinue the Ketoconazole shampoo. -He had used the last of Resident #3's Ketoconazole shampoo "the other day."	{C 342}		

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{C 342}	Continued From page 70 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 telephone interview with the House Manager on 01/29/25 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 administered. -The MAR should be used to show what medication was given on what day and at what time. -The MARs should match the medications on hand. -The MAR should match the medication label. -Any exceptions should be documented on the MAR. Telephone interview with the House Manager on 01/29/25 at 9:44am revealed: -The staff member administering the medication should compare the MAR to the medication on hand and after administering the medication, document on the MAR. -If a medication was being documented as administered every day the staff member was not paying attention and "just documenting." -The staff were not taking time to read the MAR. -He did not do MAR audits. Telephone interview with the Director on 01/29/25	{C 342}		

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{C 342}	Continued From page 71 at 10:32am revealed: -Staff should compare the MAR with the medications on hand. -Staff should look at the medications and make sure they matched the MAR before administering the medication to the residents. -Staff should only document the medications administered. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -She expected the staff to compare the medication on hand to the MAR administer the medication and then document. -She reviewed the residents' MARs when she was at the facility in December 2024. -She did not look at the medications on hand to make sure the medications ordered were in the facility.	{C 342}		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure there were readily retrievable records for controlled substances by documenting the receipt, administration, and disposition for 1 of 1 sampled resident (#1) with an order for a medication used to treat anxiety.	C 367		

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C 367	Continued From page 72 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. -There 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 8:00pm. -There 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 daily. -The pharmacy label read there were 90 tablets of Clonazepam 0.5mg dispensed on 10/30/24. -A handwritten note on one of the three CSCS was documented as started on 11/04/24. -The form was filled in with dates and times of 8:00am, 3:00pm, and 8:00pm from 11/04/24-11/13/24. -There was documentation on the first CSCS that Clonazepam 0.5mg was administered to Resident #1 on 11/04/24-11/10/24 at 8:00am, 2:00pm, and	C 367		

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8:00pm and 11/11/24 at 8:00am.
-There was no signature for the 2:00pm and 8:00pm doses on 11/11/24 and at 8:00am, 2:00pm, and 8:00pm from 11/12/24-11/13/24.
-The second CSCS dated 10/30/24 started with the date of 11/14/24 at 2:00pm and ended on 11/24/24 for the 8:00am dose.
-There was no documentation for the 8:00am dose administered on 11/14/24.
-The third CSCS dated 10/30/24 started on 11/24/24 at 8:00pm and ended on 12/04/24 for the 2:00pm dose.
-There was no documentation for the 2:00pm dose administered on 11/24/24.

Review of Resident #1's December 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 8:00pm.
-There was documentation Clonazepam 0.5mg was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 12/01/24-12/31/24.

Review of Resident #1's CSCS revealed:
-There was a CSCS with a pharmacy label that read Clonazepam 0.5mg three times daily.
-The pharmacy label read there were 90 tablets of Clonazepam 0.5mg dispensed on 12/09/24.
-The form was filled in three times a day for the dates and times Clonazepam was administered from 12/11/24 at 2:00pm-12/21/24 at 8:00am.
-There was documentation on the first CSCS that Clonazepam 0.5mg was administered to Resident #1 on 12/11/24 at 2:00pm and 8:00pm and 8:00am, 2:00pm, and 8:00pm from 12/12/24-12/20/24.
-The CSCS ended on 12/21/24 at 8:00am.
-The second CSCS dated 12/09/24 started with the date of 12/21/24 at 2:00pm and ended on

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12/31/24 for the 8:00am dose.
-The third CSCS dated 12/09/24 started on 12/31/24 at 3:00pm and ended on 01/10/25 at 8:00am.
-There was no documentation Clonazepam 0.5mg was administered on 12/04/24 at 8:00pm and three times daily from 12/05/24-12/10/24 and the 12/11/24 8:00am dose.

Review of Resident #1's January 2025 MAR from 01/01/25-01/27/25 revealed:
-There was an entry for Clonazepam 0.5mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.
-There was documentation Clonazepam 0.5mg was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 01/01/25-01/27/25.

Review of Resident #1's CSCS on 01/28/25 at 8:37am revealed:
-There was a CSCS with a pharmacy label that read Clonazepam 0.5mg three times daily.
-The pharmacy label read there were 90 tablets of Clonazepam 0.5mg dispensed on 01/16/25.
-The form was filled in three times a day for the dates and times Clonazepam was administered from 01/10/25 at 2:00pm with an end dated of 01/20/25 at 8:00am.
-There was no signature for the 2:00pm and 8:00pm doses on 01/10/25 and at 8:00am, 2:00pm, and 8:00pm from 01/11/25-01/19/25 and on 91/20/25 at 8:00am.
-The second CSCS dated 01/16/25 started with the date of 01/20/25 at 2:00pm and ended on 01/27/25 at 8:00pm.
-There was no signature for the 2:00pm and 8:00pm doses on 01/27/25.

Observation of Resident #1's medications on hand on 01/28/25 at 8:38am revealed:

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-There was a bubble pack of 30 Clonazepam 0.5mg tablets with a dispense date of 01/16/25; it was labeled as 2 of 3.
-There were 7 of 30 Clonazepam 0.5mg remaining in the bubble pack.

Second observation of Resident #1's medications on hand on 01/29/25 at 11:45am revealed:
-There was a second bubble pack of 30 Clonazepam 0.5mg tablets with a dispense date of 01/16/25; it was labeled as 3 of 3.
-There were 30 of 30 Clonazepam 0.5mg remaining in the bubble pack.

Telephone interview with the pharmacy technician from the facility's contracted pharmacy on 01/29/25 at 1:02pm revealed:
-The pharmacy had an ordered dated 10/24/24 for Resident #1's Clonazepam 0.5mg one tablet three times daily.
-Resident #1's Clonazepam 0.5mg was dispensed on 10/30/24,12/09/24, and 01/16/25; each dispensing was 90 tablets for a 30-day supply.

Telephone interview with the Supervisor-in-Charge on 01/29/25 at 11:38am revealed:
-He signed the CSCS when he administered the medication.
-As long as he signed the MAR, it did not matter if the CSCS was signed.
-The MAR was the "main" document.
-When asked why he had not signed the CSCS for the controlled medication administered on 01/27/25 he responded, "Was the count off? no it was not."

Telephone interview with the House Manager on 01/29/25 at 9:44am revealed:

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C 367	Continued From page 76 -When a staff member administered a controlled medication, it should be documented on the resident's MAR and on the CSCS. -The CSCS was not prefilled and should be documented every day at the time of the administration. Telephone interview with the Director on 01/29/25 at 10:32am revealed documenting the administration of controlled medications was the same as all medications, but to make sure it was also documented on the CSCS. Telephone interview with the Administrator on 01/29/25 at 12:24pm revealed: -She audited Resident #2's controlled medication, including the CSCS in December 2024. -She was not aware there were days in November 2024 and December 2024 the CSCS was not signed when the medication was administered. -She was concerned that controlled medications had not been signed off on.	C 367		