

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079122	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/10/2026
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NAME OF PROVIDER OR SUPPLIER RICE FAMILY CARE #3	STREET ADDRESS, CITY, STATE, ZIP CODE 116 GWYNN DRIVE REIDSVILLE, NC 27320
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C 000	Initial Comments The Adult Care Licensure Section conducted an Annual Survey on March 10, 2026.	C 000		
C 236	<p>10A NCAC 13G .0802 (a) (c) Resident Care Plan</p> <p>10A NCAC 13G .0802 Resident Care Plan</p> <p>(a) The facility shall develop and implement a care plan for each resident based on the resident's assessment completed in accordance with Rule .0801 of this Section. The care plan shall be resident-centered and include the resident's preferences related to the provision of care and services. A copy of each resident's current care plan shall be maintained in a location in the facility where it can be accessed by facility staff who are responsible for the implementation of the care plan.</p> <p>(c) The care plan shall include the following:</p> <ol style="list-style-type: none"> (1) a description of services, supervision, tasks, and level of assistance to be provided to address the resident's needs identified in the resident's assessment in Rule .0801 of this Section; (2) frequency of the services or tasks to be performed; (3) revisions of tasks and frequency based on reassessments in accordance with Rule .0801 of this Section; (4) licensed health professional tasks required according to Rule .0903 of this Section; (5) a dated signature of the assessor upon completion; and (6) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care 	C 236		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 236	<p>Continued From page 1</p> <p>services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid.</p> <p>This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) had a completed care plan that was signed by a physician or a physician's extender within 15 days of the resident being assessed.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 12/09/25 revealed: -Diagnoses included hypertension (HTN) and schizophreniform disorder. -She was admitted to the facility on 04/01/25.</p> <p>Review of Resident #1's care plan dated 12/30/25 revealed the care plan was not signed by Resident #1's Primary Care Provider (PCP).</p> <p>Interview with the Administrator on 03/10/26 at 2:14 pm revealed: - She was aware that care plans must be signed within 15 days of completion by a resident's physician or physician extender. -The nurse consultant was responsible for completion of resident care plans, but the administrator was responsible to ensure care plans were signed by the PCP.</p>	C 236		

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C 236	Continued From page 2 -She faxed Resident #1's care plan to her PCP for reviewing and signing but never received it back and she did not follow-up. -Both she and the nurse consultant conducted chart audits quarterly. -It was her expectation that all resident care plans be completed timely and PCP signatures obtained within the 15-day timeframe. Attempted telephone interview with Resident #1's PCP on 03/10/26 at 3:24 pm was unsuccessful.	C 236		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (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).	C 342		

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C 342	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled residents' Electronic Medication Administration Record (eMAR) was accurate regarding administration of a high blood pressure medication (#2).</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 01/15/26 revealed: -Diagnoses included hypertension (HTN), bipolar disorder, claustrophobia, depression and schizophreniform disorder. -There was an order for Losartan, 25mg once daily in the am.</p> <p>Review of Resident #2's signed physician order dated 01/16/26 revealed the Losartan was increased to 50mg daily in the am and the previous order for the 25mg dosage was discontinued.</p> <p>Review of Resident #2's January 2026 MAR revealed: -There was an entry for Losartan 25mg scheduled at 8:00am. -There was an entry for Losartan 50mg scheduled at 8:00am 01/17/26-01/31/26. -There was documentation that Losartan 25mg was administered from 01/01/26-01/31/26. -There was documentation that Losartan 50mg was administered from 01/17/26-01/31/26.</p> <p>Observation of medications available to Resident #2 at 1:27pm on 3/10/26 revealed: -There was one card of blister pack medications containing Losartan 50mg, take 1 tablet daily at 8am.</p>	C 342		

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C 342	<p>Continued From page 4</p> <ul style="list-style-type: none"> -Losartan was dispensed to the facility on 02/18/26 with a quantity of 28 capsules. -There were 16 out of 28 tablets of the Losartan remaining in the blister packs. <p>Interview with Resident #2 at 1:42pm on 03/10/26 revealed:</p> <ul style="list-style-type: none"> -She knew she was prescribed medication for her blood pressure but could not recall the name, dosage or frequency. -She was unaware of how much blood pressure medication had been administered to her in January. <p>Telephone interview with the facility's contracted pharmacy on 03/10/26 at 1:49pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 had a current order for Losartan 50mg dated 01/16/26. -The pharmacy dispensed 30 tablets of Losartan 25mg to the facility on 10/16/25, 11/13/25 and 12/16/25. -The pharmacy dispensed 30 tablets of Losartan 50mg to the facility on 01/16/26 and 28 tablets on 2/18/26. -If administered once daily as ordered, there would have been no 25mg tablets remaining to dispense to Resident #1 beyond 01/16/26. -It was the pharmacy's policy to pick up any remaining discontinued medications from the facility within 24 hours of receiving an order from the PCP. -The pharmacy delivered the 50mg dosage of the Losartan to the facility on 01/16/26, provided a new MAR sheet, provided a copy of the new order and provided a copy of the discontinued order. <p>Interview with the Medication Aide (MA) on 03/10/26 at 1:22pm revealed:</p> <ul style="list-style-type: none"> -She was aware that Resident #2's Losartan 	C 342		

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C 342	<p>Continued From page 5</p> <p>order had changed.</p> <p>-She did not administer the 25mg dosage of the Losartan after 01/16/26 because there were no remaining tablets, but she did initial the MAR sheets for both the 25mg and the 50mg.</p> <p>-If there were any tablets remaining of the 25mg, the pharmacy would have picked them up on 01/16/26.</p> <p>Interview with the Administrator at 2:14pm on 03/10/26 revealed:</p> <p>-She was aware of Resident #2's order for the increase in her Losartan because she transported Resident #2 to her PCP appointment..</p> <p>-She completed monthly MAR audits, and a nurse consultant completed them quarterly.</p> <p>-The facility's contracted pharmacy completed MARs, provided new MARs when delivering new medications, picked up discontinued medications and provided orders for discontinued medications.</p> <p>-It was her expectation for the MA to initial MARs accurately.</p> <p>-She expected the MA to strike through remaining dates and write "DC" on the MAR when a medication was discontinued.</p>	C 342		