STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017042	A. BUILDING: _____ B. WING _____	05/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKER'S FAMILY CARE HOME	10123 WADE DEAD ROAD CEDAR GROVE, NC 27231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow-up survey May 8, 2019.	C 000		
C 273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 8 ounces of milk was served to the residents twice daily. The findings are: Interview with a resident on 05/08/19 at 8:32am revealed: -He liked to drink milk. -He sometimes had milk to drink at breakfast. -He thought he had cereal "about every other day." Interview with a second resident on 05/08/19 at 8:45am revealed: -He had milk in his cereal. -He was never offered milk to drink in a cup. -He liked milk and would drink it at every meal if it was offered.	C 273	Parker's Family Care will serve milk to Residents twice daily 5/9/19 -A sign has been posted on the refrigerator to remind staff to serve milk daily. -The Administrator will make unscheduled visits to the facility during various meal times 2 x's per week x 4 weeks and then 1 x month to assure ongoing compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeff Dr. P. Haw — TITLE: Administrator — (X6) DATE: 6/20/19

Reviewed and accepted with addendums on (page 1, 3 & 11). 06/20/19 Kathy Gray

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C 273	Continued From page 2 breakfast. -He served the residents' water and fruit punch or another flavored drink mix at lunch. -He served the residents' water and fruit punch or another flavored drink mix at dinner. -He sometimes offered milk, and the residents would drink the milk. -He offered milk 2-3 times per week; he could not recall when he offered milk to the residents. Interview with the Administrator on 05/08/19 at 6:44pm revealed: -Residents were offered water, apple juice and sometimes milk to drink at breakfast. -Residents were offered water, fruit punch and tea to drink at lunch; some residents had drinks they had purchased. - Residents were offered water, fruit punch and tea to drink at dinner. -Milk was served at breakfast; milk was not served at any other meal. -She thought some of the residents might drink milk if it was offered.	C 273		
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	C 342	Parker's Family Care met with staff to ensure the importance of being more careful when signing MAR Staff will + make every effort to not omitt any dates that meds are passed.	5/9/19

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C 342	Continued From page 5 she had not noticed the MA had signed his initials daily for Vitamin D. b. Review of Residents #5's medication orders dated 04/10/19 revealed: -There was an order for Clonidine HL 0.3mg take one tablet twice daily. (Clonidine is used to treat high blood pressure.) -There was an order for stool softener 100mg take one tablet twice daily. -There was an order for Amlodipine 2.5mg take one tablet twice daily. (Amlodipine is used to treat high blood pressure.) -There was an order for Cetirizine HCL 10mg take one tablet at bedtime. (Cetirizine is used to treat allergy symptoms.) -There was an order for Haloperidol 5mg take one and one-half tablets at bedtime. (Haloperidol is used to treat mental disorders.) -There was an order for Niacin ER 1000mg take one tablet at bedtime. (Niacin is used to treat high cholesterol.) -There was an order for Carvedilol 25mg take one tablet twice a day. (Carvedilol is used to treat high blood pressure.) -There was an order for Benztropine 0.5mg take one tablet twice a day. (Benztropine is used to treat the side effects of other medications). Review of Resident #5's medication administration record for April 2019 revealed: -There was an entry for Clonidine HCL 0.3mg one tablet twice daily scheduled at 8:00am and 8:00pm. -Clonidine was not documented as administered on 04/30/19 at 8:00pm. -There was an entry for stool softener one tablet twice daily scheduled at 8:00am and 8:00pm. -Stool softener was not documented as administered on 04/30/19 at 8:00pm.	C 342	-The Administrator will schedule a continuing education class with the pharmacy for MARs and Medication Errors. -The Administrator will continue to audit MARs every 2 weeks.	7/01/19

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C 342	Continued From page 6 -There was an entry for Amlodipine 2.5mg one tablet twice daily scheduled at 8:00am and 8:00pm. -Amlodipine was not documented as administered on 04/30/19 at 8:00pm. -There was an entry for Cetirizine HCK 10 mg one tablet daily was scheduled at 8:00pm. -Cetirizine was not documented as administered on 04/30/19 at 8:00pm. -There was an entry for Haloperidol 5mg take one and one-half tablets at bedtime was scheduled at 8:00pm. -Haloperidol was not documented as administered on 04/30/19 at 8:00pm. -There was an entry for Niacin ER 1000mg take one tablet at bedtime was scheduled at 8:00pm. -Niacin was not documented as administered on 04/30/19 at 8:00pm. -There was an entry for Carvedilol 25mg take one tablet twice a day was scheduled at 8:00am and 8:00pm. -Haloperidol was not documented as administered on 04/30/19 at 8:00pm. -There was an entry for Benztropine 0.5mg take one tablet twice a day was scheduled at 8:00am and 8:00pm. -Benztropine was not documented as administered on 04/30/19 at 8:00pm. Observation of Resident #5's medications on hand on 05/08/19 at 3:24pm revealed there were current supplies of Clonidine, stool softener, Amlodipine, Cetirizine, Haloperidol, Niacin, Carvedilol, and Benztropine available to be administered. Interview with Resident #5 on 05/08/19 at 4:35pm revealed: -He took medications in the morning and at night. -He had not missed any medications.	C 342		

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C 342	Continued From page 8 -Niacin was not documented as administered on 04/30/19 at 8:00pm. -There was an order for Simvastatin 40mg one tablet daily scheduled at 8:00pm. -Simvastatin was not documented as administered on 04/30/19 at 8:00pm. -There was an order for Fluvoxamine Maleate 100mg one and one half tablets daily scheduled at 8:00pm. -Fluvoxamine was not documented as administered on 04/30/19 at 8:00pm. -There was an order for Clozapine 100mg one and one-half tablets daily scheduled at 8:00pm. -Clozapine was not documented as administered on 04/30/19 at 8:00pm. Observation of Resident #4's medications on hand on 05/08/19 at 3:03pm revealed there were current supplies of Benztropine Mesylate, Niacin, Simvastatin, Fluvoxamine and Clozapine available to be administered. Interview with Resident #4 on 05/08/19 at 4:38pm revealed: -He took medications in the morning and at night. -He had not missed any medications. Refer to the interview with the Supervisor-in-Charge (SIC) on 05/08/19 at 6:09pm. Refer to with the interview with the Administrator on 05/08/19 at 4:59pm. 3. Review of Resident #2's current FL-2 dated 11/15/18 revealed: -Diagnoses included Schizoaffective, Diabetes Type 1, Pancreatitis, Mild Mental Retardation, and High Cholesterol. -There was an order for Clonazepam 0.5mg one	C 342		

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C 342	Continued From page 10 the end of the month. -She had not audited the MARs in May. -She expected the MA to sign the MAR at the time the medication was administered. -She did not know the MA had not signed he had administered the evening medications on 04/30/19.	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, interviews, and record reviews, the facility failed to assure a readily retrievable record in order to accurately reconcile controlled substances for 4 of 4 sampled residents (#1, #2, #3, #6) who had orders for a controlled substance. The findings are: 1. Review of Resident #1's current FL-2 dated 11/15/18 revealed diagnoses including bipolar schizoaffective, multiple sclerosis, osteoporosis, hyperactive bladder, asthma allergies. a. Review of a physician's order for Resident #1 dated 11/15/18 revealed an order for Clonazepam 0.5mg three times daily. (Clonazepam is used to treat anxiety).	C 367	Parker's Family Care will implement the Control log to keep Count of control meds, The Administrator will complete chart audits every 2 weeks to ensure control logs are being utilized correctly.	6/1/19

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C 367	Continued From page 12 pharmacy's contracted pharmacy on 05/08/19 at 4:21pm revealed (3) packs of 31 tablets of Lorazepam 0.5mg had been dispensed on 04/23/19; there were no other dispenses. Interview with the pharmacy consultant on 05/08/19 at 4:30pm revealed: -She had completed pharmacy reviews for Resident #1 on 04/19/19. -She did not look at the control sheets or the medications on hand. -This was her first facility pharmacy review. -She looked at the FL-2, signed physician's orders and the MARs. -Control sheet logs were sent to the facility with each control medication. -She expected the facility staff to use the control sheet logs when administering controlled medication. Interview with the Administrator/Medication aide (MA) on 05/08/19 at 2:05pm revealed: -She did not have control logs for controlled medication. -The pharmacy sent control logs each month with the controlled medication. -She had never used the control logs; they just did not do the extra step. -The controlled medication was documented on the MAR when it was administered. -She did not know why the control logs were needed if it was already documented on the MAR. b. Review of a physician's order for Resident #1 dated 11/15/18 revealed an order for Lorazepam 0.5mg one tablet twice daily as needed for anxiety. (Lorazepam is used to treat anxiety). Attempted review of Resident #1's controlled substances logs (CSL) for Lorazepam revealed	C 367		

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C 367	Continued From page 14 medication. Interview with the Administrator/Medication aide (MA) on 05/08/19 at 2:05pm revealed: -She did not have control logs for controlled medication. -The pharmacy sent control logs each month with the controlled medication. -She had never used the control logs; they just did not do the extra step. -The controlled medication was documented on the MAR when it was administered. -She did not know why the control logs were needed if it was already documented on the MAR. c. Review of a physician's order for Resident #1 dated 11/15/18 revealed an order for Tramadol 50mg one tablet three times a day as needed. (Tramadol is used to treat moderate to severe pain). Attempted review of Resident #1's controlled substances logs (CSL) for Tramadol revealed there were no controlled substances logs available for review for February 2019-May 2019. Review of Resident #1's February 2019-May 2019 medication administration record (MAR) on 05/08/19 revealed: -There was an entry for Tramadol 50mg take 1 tablet three times a day as needed. -Tramadol was documented as administered on 03/29/19 and 04/25/19; there was no other documentation that Tramadol had been administered. Observation of Resident #1's medications on hand on 05/08/19 at 5:06pm revealed: -A bubble pack of 20 tablets of Tramadol 50mg tablets was dispensed on 11/21/18.	C 367		

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C 367	Continued From page 16 11/15/18 revealed diagnoses including schizoaffective, diabetes, pancreatitis, mild mental retardation and high cholesterol. a. Review of a physician's order for Resident #2 dated 11/15/18 revealed an order for Clonazepam 0.5mg twice a day. (Clonazepam is used to treat anxiety). Attempted review of Resident #2's controlled substances logs for Clonazepam revealed there were no controlled substances logs available for review for February 2019-May 2019. Review of Resident #2's February 2019-May 2019 medication administration record (MAR) on 05/08/19 revealed: -There was an entry for Clonazepam 0.5mg take one tablet twice a day scheduled at 8:00am and 8:00pm. -Clonazepam was documented as administered two times a day from 02/01/19 through 05/07/19; the am dose for 05/08/19 was documented as administered. Observation of Resident #2's medications on hand on 05/08/19 at 1:52pm revealed: -There were two bubble packs of Clonazepam 0.5mg tablets dispensed from the pharmacy on 04/23/19 each with a quantity of 31 tablets. -The instructions were to take one tablet by mouth at 8:00am and 8:00pm. -Each individual bubble pack was labeled with the date and time for the medication to be administered. -The bubble packs for the 8:00am dose for 05/05/19 through 05/08/19 had been administered; 27 tablets remained in the individual bubble packs. -The bubble packs for the 8:00pm dose for	C 367		

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C 367	Continued From page 18 0.5mg once a day as needed for anxiety. (Clonazepam is used to treat anxiety). Attempted review of Resident #2's controlled substances logs for Clonazepam revealed there were no controlled substances logs available for review for February 2019-May 2019. Review of Resident #2's February 2019-May 2019 medication administration record (MAR) on 05/08/19 revealed: -There was an entry for Clonazepam 0.5mg take one tablet once a day prn as needed for anxiety. -Clonazepam was not documented as administered from 02/01/19 through 05/08/19. Observation of Resident #2's medications on hand on 05/08/19 at 1:52pm revealed: -There was a bubble pack of Clonazepam 0.5mg tablets dispensed from the pharmacy on 01/19/17 each with a quantity of 30 tablets. -The instructions were to take one tablet by mouth once a day as needed for anxiety. -One of 30 tablets had been administered since 11/21/18; 29 tablets were available. Interview with a representative from the pharmacy's contracted pharmacy on 05/08/19 at 4:21pm revealed (2) packs of 31 tablets of Lorazepam 0.5mg had been dispensed on 04/23/19. Interview with the pharmacy consultant on 05/08/19 at 4:30pm revealed: -She had completed pharmacy reviews for Resident #1 on 04/19/19. -She did not look at the control sheets or the medications on hand. -This was her first facility pharmacy review. -She looked at the FL-2, signed physician's	C 367		

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C 367	Continued From page 20 -Temazepam was documented as administered every night from 02/01/19 through 05/07/19. Observation of Resident #2's medications on hand on 05/08/19 at 1:52pm revealed: -There was a bubble pack of Temazepam 15mg tablets dispensed from the pharmacy on 04/23/19 each with a quantity of 31 tablets. -The instructions were to take one tablet by mouth at 8:00pm. -Each individual bubble pack was labeled with the date and time for the medication to be administered. -The bubble packs for the 8:00pm dose for 05/05/19 through 05/07/19 had been administered; 28 tablets remained in the individual bubble packs. Interview with a representative from the pharmacy's contracted pharmacy on 05/08/19 at 4:21pm revealed one pack of 31 tablets of Temazepam 15mg had been dispensed on 04/23/19. Interview with the pharmacy consultant on 05/08/19 at 4:30pm revealed: -She had completed pharmacy reviews for Resident #1 on 04/19/19. -She did not look at the control sheets or the medications on hand. -This was her first facility pharmacy review. -She looked at the FL-2, signed physician's orders and the MARs. -Control sheet logs were sent to the facility with each control medication. -She expected the facility staff to use the control sheet logs when administering controlled medication. Interview with the Administrator/Medication aide	C 367		

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C 367	Continued From page 22 -There was a bubble pack of Lorazepam 0.5mg -A bubble pack of 35 tablets of Lorazepam 1mg tablets was dispensed on 12/26/17. -On 05/08/19, there were 27 Lorazepam tablets remaining. -Eight of 35 tablets had been administered since 11/17/17. Interview with a representative from the pharmacy's contracted pharmacy on 05/08/19 at 4:21pm revealed 35 tablets of Lorazepam 0.5mg had been dispensed on 12/26/17; there were no other dispenses. Interview with the pharmacy consultant on 05/08/19 at 4:30pm revealed: -She had completed pharmacy reviews for Resident #1 on 04/19/19. -She did not look at the control sheets or the medications on hand. -This was her first facility pharmacy review. -She looked at the FL-2, signed physician's orders and the MARs. -Control sheet logs were sent to the facility with each control medication. -She expected the facility staff to use the control sheet logs when administering controlled medication. Interview with the Administrator/medication aide (MA) on 05/08/19 at 2:05pm revealed: -She did not have control logs for controlled medication. -The pharmacy sent control logs each month with the controlled medication. -She had never used the control logs; they just did not do the extra step. -The controlled medication was documented on the MAR when it was administered. -She did not know why the control logs were	C 367		