STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035021	A. BUILDING: _____ B. WING _____	R 07/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE FAMILY CARE HOME III	45 CANNADY WAY FRANKLINTON, NC 27525

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on July 16, 2021.	C 000		
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 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#3) related to a medication used to treat mental and mood disorders. The findings are: Review of Resident #3's current FL-2 dated 10/16/20 revealed: -Diagnosis included schizophrenia and acute encephalopathy. -There was a medication order for paliperidone extended release (ER) (used to treat mental/mood disorders) 6 mg daily. Review of Resident #3's Psychiatric provider orders revealed: -There was an order dated 03/11/21 to discontinue paliperidone ER 3 mg.	C 330		

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C 330	Continued From page 1 -There was an order dated 05/28/21 to discontinue paliperidone ER 3 mg. -There was an order dated 07/14/21 for paliperidone ER 3 mg daily. Review of Resident #3's six-month physician orders revealed: -Resident #3's primary care provider signed the orders on 05/20/21. -There was a medication order for paliperidone ER 3 mg daily. Review of Resident #3's May 2021 printed medication administration record (MAR) revealed: -There was an entry for paliperidone ER 3mg, scheduled for 8:00am. -There was documentation of administration of paliperidone ER 3 mg from 05/01/21 to 05/31/21 at 8:00am. Review of Resident #3's June 2021 printed MAR revealed: -There was an entry for paliperidone ER 3mg, scheduled for 8:00am. -There was documentation of administration of paliperidone ER 3 mg from 06/01/21 to 06/30/21 at 8:00am. Review of Resident #3's July 2021 printed MAR revealed: -There was a handwritten entry for paliperidone ER 3mg, scheduled for 8:00am. -There was documentation of administration of paliperidone ER 3 mg from 07/15/21 to 07/16/21 at 8:00am. Observation of Resident #3's medications in the facility on 07/16/21 at 1:11pm revealed: -There was a bubble package of paliperidone 3 mg dispensed on 07/14/21.	C 330		

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C 330	Continued From page 2 -There were 15 tablets remaining in the bubble package. -There were 17 tablets were dispensed on 07/14/21. Review of Resident #3's pharmacy dispensing records revealed: -There were 31 tablets of paliperidone dispensed on 04/16/21. -There were 30 tablets of paliperidone dispensed in June 2021, and there was no specific dated on the dispensing record. -There were 30 tablets of paliperidone dispensed on 05/20/21. Telephone interview with a representative at Resident #3's facility contracted pharmacy on 07/16/21 at 2:13pm revealed: -There was an order dated 05/28/21 to discontinue paliperidone ER 3 mg. -Paliperidone 3 mg appeared on Resident #3's June 2021 MAR because the new MARs were already sent to the facility. -Staff at the facility had to make changes to the new MARs once they were sent to the facility. -The pharmacy sent a single page MAR if there was a new medication order. -Thirty-one tablets of paliperidone 3 mg was dispensed for Resident #3 on 04/16/21. -She did not see any other dispensing dates after 04/16/21 for paliperidone. Interview with the Supervisor-in-Charge (SIC) on 07/16/21 at 3:05pm revealed: -She started working at the facility in April 2021. -She administered medications to Resident #3 in the morning before he left for the day program. -She knew Resident #3 had an order to discontinue paliperidone for May 2021. -The pharmacist who completed the medication	C 330		

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C 330	Continued From page 3	C 330		

review told her in May 2021 that Resident #3's paliperidone was discontinued in March 2021.
-Because she was a new medication aide (MA), she contacted Resident #3's Psychiatric provider but did not hear back from the provider's office.
-She continued to administer paliperidone to Resident #3 in June 2021 because the pharmacy kept sending the medication.
-She administered paliperidone in May 2021 to Resident #3 because she was not aware of the 03/11/21 discontinue order for paliperidone.
-She stopped administering paliperidone to Resident #3 in July 2021 because it was not on the July 2021 MAR.
-Resident #3's behavior changed once his paliperidone was not administered.
-Resident #3's Psychiatric provider's office was contacted for an appointment to evaluate his behavior.
-Resident #3 was seen on 07/14/21 by his Psychiatric provider and paliperidone was reordered.
-The facility started using a new pharmacy at the beginning of the month of July 2021.
-The new pharmacy filled the prescription dated 07/14/21.
-She checked the medications when they were delivered from the pharmacy using the current MAR.
-She wrote new orders on the MAR when new medications were delivered from the pharmacy.

Interview with the Owner/Administrator designee on 07/16/21 at 4:30pm revealed:
-Staff were expected to fax orders and prescriptions to the pharmacy.
-Staff were expected to verify that the fax was received by the pharmacy by calling them.
-He did not know Resident #3 was administered paliperidone after the medication was

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C 330	Continued From page 4 discontinued. -He thought the Psychiatric provider sent the discontinue order electronically and the provider did not communicate with staff. -He expected staff to remove the medication from the medication cabinet when it was discontinued, write discontinued on the MAR beside the medication entry with the date of the discontinue order and highlight the medication entry. -He was responsible for ensuring medications were administered as ordered by the resident's provider. Based on observations, record reviews, and interviews, it was determined that Resident #3 was not interviewable. Attempted telephone interview with Resident #3's Psychiatric provider on 07/16/21 at 1:55pm was unsuccessful.	C 330		