STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093001	A. BUILDING: _____ B. WING _____	11/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOYD'S REST HOME # 2	295 CARROLLTOWN ROAD MACON, NC 27551

(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
D 000	Initial Comments The Adult Care Licensure Section and the Warren County Department of Social Services conducted an annual survey on 11/08/21.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (Resident #2) related to a medication used to treat depression. The findings are: Review of Resident #2's current FL-2 dated 11/02/21 revealed: -There were no diagnoses listed on the FL-2. -There was an order for fluoxetine (used to treat depression) 40mg take one capsule at bedtime. Review of Resident #2's primary care provider's (PCP) orders faxed to the facility on 11/08/21	D 344		

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D 344	Continued From page 1	D 344		

revealed there was an order dated 09/09/21 for fluoxetine 20mg take one capsule in the evening.

Review of Resident #2's October 2021 medication administration record (MAR) revealed:
-There was an entry for fluoxetine 40mg take one capsule in the evening scheduled for administration at 8:00pm.
-There was documentation fluoxetine 40mg was administered 31 of 31 opportunities.

Review of Resident #2's November 2021 MAR revealed:
-There was an entry for fluoxetine 40mg take one tablet in the evening/at bedtime with no specific time of administration indicated.
-There was documentation fluoxetine 40mg was administered 7 of 7 opportunities.

Observation of Resident #2's medication available for administration on 11/08/21 revealed:
-There was one bottle with a label indicating 90 fluoxetine 40mg tablets were dispensed from the pharmacy on 09/10/21.
-There were 43 tablets in the bottle.

Second observation of Resident #2's medication available for administration on 11/08/21 revealed:
-There was one bottle with a label indicating 90 fluoxetine 20mg tablets were dispensed from the pharmacy on 07/28/21.
-There were 29 tablets in the bottle.

Telephone interview with a pharmacist from Resident #2's pharmacy on 11/08/21 at 2:35pm revealed:
-There was an order dated 09/09/21 for fluoxetine 40mg take one tablet at bedtime.
-There was a previous order for fluoxetine 20mg take one tablet at bedtime that had not been

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	HAL093001	A. BUILDING: _____ B. WING _____	11/08/2021

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D 344	Continued From page 2	D 344		

discontinued.
-The orders were written by two different healthcare providers.

Interview with the Administrator on 11/08/21 at 2:05pm revealed:
-Resident #2's admission paperwork was completed on 09/17/21.
-Resident #2 was admitted to the facility on 10/01/21.
-Resident #2's family member told him to "hold" the fluoxetine 40mg on 09/17/21.
-He was in the process of getting Resident #2's orders up to date.

Telephone interview with Resident #2's family member on 11/08/21 at 3:06pm revealed:
-Resident #2 was admitted to the facility in early October 2021.
-Resident #2 took her medication with her when she was admitted to the facility.
-Resident #2 was initially prescribed fluoxetine 20mg and then it was increased to 40mg at some point.
-Resident #2's fluoxetine dose may have been decreased at the end of September 2021 or early October 2021.
-She did not know the current dose of Resident #2's fluoxetine.

Telephone interview with a Registered Nurse (RN) from Resident #2's PCP's office on 11/08/21 at 4:37pm revealed:
-Resident #2 was prescribed fluoxetine 40mg on 09/09/21.
-The fluoxetine order was changed to 20mg on 09/22/21 because Resident #2 was at risk for falls.