STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl074052	A. BUILDING: _____ B. WING _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
L & C FAMILY CARE HOME #2	4224 WASHINGTON STREET AYDEN, NC 28513

(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 initial survey and complaint investigation on 03/23/22.	C 000		
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 substantiated 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 1 of 3 sampled staff (Staff A) was verified through the North Carolina Health Care Personnel Registry (NC HCPR) upon hire. The findings are: Review of Staff A's facility personnel record revealed: -Staff A was hired on 03/14/22. -There was no documentation of a Health Care Personnel Registry check (HCPR) being completed upon hire. Interview with Staff A on 03/23/22 at 8:15am revealed: -It was his second week working at the facility. -He was a personal care aide and his main duties included assisting residents as needed, cooking and preparing meals, and cleaning the facility. Interview with the Administrator on 03/23/22 at	C 145		

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C 145	Continued From page 1 8:55am and 5:35pm revealed: -She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents to include checking HCPR on staff prior to their start date. -She had employees that came in during the day from 7:00am to 7:00pm to assist her in caring for the residents and maintaining the home. -Staff A started working at the facility as a personal care aide approximately two weeks ago. -She did not realize she had forgotten to screen Staff A's HCPR prior to him starting at the facility; it just slipped through the cracks.	C 145		
C 148	10A NCAC 13G .0406 (8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications Each staff person of a family care home shall (8) maintain a valid driver's license if responsible for transportation of residents; and This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had and maintained a valid driver's license upon hire who transported a resident to another facility for a day program. The findings are: Observation of the facility's transport van on 03/23/22 at 8:05am revealed: -There was a large white van parked in front of the facility with damage to the right side. -The right side of the van was missing a strip of	C 148		

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C 148	Continued From page 2	C 148		

the outer body along the bottom of the vehicle from the front right wheel along the passenger front and middle doors.
-The right side of the van was dented and scratched from the windows down to the bottom of the vehicle on the passenger door and body of the van up to the rear right wheel.

Review of Staff B's facility personnel record revealed:
-Staff B was hired on 11/01/21.
-There was no verification of a valid driver's license being completed upon hire.
-There was no documentation of a valid driver's license in the record at all.

Interview with Resident #3 on 03/23/22 at 1:35pm revealed:
-He was with Staff B in the facility van seated behind Staff B on the driver's side the day of the vehicle accident.
-He did not remember anything about the incident except "getting hit" and that there was another car accident that was ahead of them on the same road.
-He did not speak with the police officer and did not have any injuries or go to the hospital.
-He did not recall the police officer saying anything about the status of the Staff B's driver's license.
-He would ride in the facility vehicle a lot with the Staff B before and after the car accident to go to the store to buy supplies or to visit other residents at another family care home (FCH).

Review of Staff B's personal record on 03/23/22 at 6:00pm revealed there was no documentation of a valid driver's license on file.

Interview with Staff B on 03/23/22 at 9:15am

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C 148	Continued From page 3 revealed: -She began working at the facility in 2017 and split her time at that facility and another FCH owned by the Administrator and was usually at the facility Monday - Friday from 9:00am to 4:00pm. -She had been running late on 02/07/22 and was taking the facility van to the other FCH owned by the Administrator to take those residents to a day program. -She did not know the Administrator's family member had planned to take the residents at the other FCH to the day program and she was trying to help keep things normal while the Administrator was on leave. -She had Resident #3 in the van with her, he was seated behind her driver's seat in the second row and they both wore their seatbelts. -They encountered a vehicular accident when she was turning left at a stop sign while on the way to the other FCH. -There was another accident ahead of her and she thought traffic was stopped due to that accident; she did not see the car that hit the facility van coming when she turned left at the stop sign. -The vehicle that hit that van was driving straight ahead on the road and did not have a stop sign to prevent them from hitting the facility van. -She thought she had a valid driver's license and was not aware that her license had been suspended until a police officer that responded to the accident notified her of the issue after running her license. -She had never driven the van or residents prior to the accident or since the accident because transportation of residents was not part of her normal duties. Review of the accident police report dated	C 148		

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C 148	Continued From page 4 02/07/22 revealed: -The accident occurred between the facility van and another vehicle on 02/07/22 at 7:32am. -The other vehicle was traveling north on the road. -The facility van was also traveling north on the road and collided with the other vehicle after failing to yield at a stop sign when turning left onto the road. -After impact, the facility van came to a controlled rest on the should of the road and the other vehicle ran off the right side of the road and collided with a ditch coming to an uncontrolled rest. Interview with the Administrator on 03/23/22 at 8:55am revealed: -She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents. -She had employees that came in during the day from 7:00am to 7:00pm to assist her in caring for the residents and maintaining the home. -Staff B was driving the facility van with Resident #3 seated behind Staff B in the driver's seat on 02/07/22 and they were involved in an accident. -She was not aware that Staff B's license had been suspended. -She or her family member would have normally provided transport to the residents, but she was hospitalized at the time with a serious illness and her family member was at her bedside. Telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm revealed that she expected the facility to ensure staff driving residents around maintained a valid driver's license for resident safety.	C 148		

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C 246	Continued From page 5	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: Based on observations, interviews and record review, the facility failed to notify the primary care provider for 1 of 3 sampled residents (#2) related to aggressive behaviors upon admission. The findings are: Review of the facility's Health Care policy dated 03/2017 revealed the facility would ensure that any referrals and follow up appointments needed to meet the resident's routine severe health care needs would be accomplished. Review of the facility's Accidents and Incidents Policy dated 03/2017 revealed all incidents should be recorded, investigated, and initiated with corrective action as necessary Review of the facility's Accidents and Incidents Policy dated 03/2017 revealed physical aggression or assault by residents or staff would be managed by referring them to the local management entity for mental health services. Review of the facility's Resident Assessment policy dated 03/2017 revealed: -The facility would ensure an assessment of the resident was completed within 10 days if a resident had a significant change. -A significant change could mean any of the following: -A change in the behavior or mood to the point	C 246		

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C 246	Continued From page 6	C 246		

where daily problems arise or relationships became problematic.
-A referral would be made immediately when changes are identified that pose an immediate risk to the health and safety of the resident, other residents, or staff at the facility.

Review of Resident #2's current FL-2 dated 03/08/22 revealed:
-Diagnoses included schizoaffective disorder, bipolar disorder, and hypertension.
-The resident was ambulatory.

Review of Resident #2's hospital after visit discharge summary dated 03/09/22 revealed:
-The resident was seen for a diagnosis of schizoaffective disorder who presented with worsening psychosis and agitation.
-As a condition of discharge, the resident was to follow-up with the appropriate out-patient psychiatric provider as scheduled on 03/16/22 at 12:30pm.
-He was to seek additional medical care for any increase in or new symptoms related to thoughts of wanting to hurt himself, hurt others, or for increased agitation.
-He was to follow up with his provider within 7-10 days of his discharge.

Review of Resident #3's progress notes revealed:
-On 03/09/22 the resident was admitted to the facility.
-On 03/10/22 the resident was documented as agitated, with irate speech, sweating, "extremely hyped", and aggressive toward staff; he did not sleep and walked the facility most of the night and his guardian was notified the next morning.
-On 03/11/22, the resident was documented as being calmer than the day before and "not as aggressive with staff".

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C 246	Continued From page 7 Intermittent observations of Resident #2 on 03/23/22 from 8:15am to 7:00pm revealed the resident to be calm, easily redirected, and respectfully interactive with other residents, staff, and visitors. Interview with the Supervisor in Charge (SIC) on 03/23/22 at 12:35pm revealed: -Resident #2 did not go to the mental health follow up appointment on 03/16/22 as scheduled by the hospital at his discharge because his insurance was not accepted by that provider. -She thought she canceled the appointment for Resident #2 due to the insurance issue but could not remember. -Because Resident #2's insurance was not accepted by the original provider, she called and made Resident #2 an appointment with the facility's contracted mental health provider (MHP) instead for 04/01/22. Interview with the Administrator on 03/23/22 at 8:55am revealed she lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents. Interview with the Administrator and the Supervisor in Charge (SIC) on 03/23/22 at 9:22am revealed: -Residents were seen by the primary care provider (PCP) and the mental health provider (MHP) via telehealth at the facility as needed. -Residents only left the facility once per month for activities, but if resident appointments were not telehealth visits, the providers would physically come to the facility. Interview with the Administrator on 03/23/22 at 5:35pm revealed:	C 246		

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C 246	Continued From page 8 -Resident #2 could be very demanding because he would become fixated on his personal beliefs and tried to force them on others. -Resident #2 was on his best behavior today because there were visitors in the facility, but he had several escalations of behaviors since his admission. -When Resident #2 was first admitted, it was a nightmare to try to calm him down and he was "in her face" on day 1 and 2; she reported this behavior to his guardian who quit shortly after the resident's admission to the facility. -The resident had a habit of yelling, cursing, and getting into people's personal space, and the behaviors were on-going. -There was one incident when the resident dipped his cigarette in some body oil and when she redirected him, he began yelling and jumping outside to a point that she almost called the police, but he finally calmed down on his own. -There was another incident when he was upset that he called a crisis center to let them know that he was not in mental health crisis, but that he was upset because he wanted his own apartment. -The crisis center called her and when she notified them that he had a guardian they left the issue to her to handle. -She did not know Resident #2's history of behaviors, and even though a staff member indicated to her that she was fearful of the resident at times, she did not report the resident's behaviors to the mental health provider (MHP) because she expected some behaviors in the beginning of the new transition of moving to a new environment and home and because he had some insurance issues causing his appointment to be delayed and didn't think they could expedite him being seen by the provider. -She was not concerned at any time that Resident #2 would hurt himself or others and she	C 246		

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C 246	Continued From page 9 had never personally felt threatened. Telephone interview with the first mental health provider's (MHP) secretary on 03/23/22 at 3:26pm revealed: -Resident #2's appointment for 03/16/22 at 12:30pm was canceled by the SIC due to insurance issues. -She was not sure if the delay in Resident #2's appointment with a new provider on 04/01/22 would be of concern. Telephone interview with the facility's contracted MHP on 03/23/22 at 3:33pm revealed: -She had not seen Resident #2 yet since his admission but had an appointment scheduled to see him on 04/01/22. -After reviewing his medication list, the resident was on a lot of heavy antipsychotic medications and she would have expected the facility to notify her of any behaviors the resident was having. -It was appropriate to cancel Resident #2's MHP appointment on 03/16/22 due to insurance issues as long as he was stable. -She had not been made aware of Resident #2's behaviors, but if the facility had notified her of Resident #2's documented behaviors, she would have wanted to see the resident sooner than the 04/01/22 scheduled appointment. -She had not yet assessed Resident #2 but would have wanted him to be assessed by either provider sooner due to the documented behaviors.	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:	C 249		

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C 249	Continued From page 10 (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 ensure implementation of physician's orders for 1 of 3 sampled residents (#3) regarding orders for a urinary analysis lab. The findings are: Review of Resident #3's current FL-2 dated 12/08/22 revealed: -Diagnoses included schizoaffective disorder, bipolar, neurocognitive disorder, history of anxiety, hyperlipidemia, constipation, seborrheic dermatitis, and type 2 diabetes. -The resident was assessed as ambulatory and continent of bladder and bowel. Review of Resident #3's primary care provider (PCP) visit report dated 03/01/22 revealed there was an order to obtain a urinary analysis (U/A) to rule out a urinary tract infection (UTI) due to increased urination that may also be related to increased caffeine intake. Review of Resident #3's record revealed there was no documented of a U/A being obtained or resulted. Interview with the Administrator on 03/23/22 at 8:55am, 2:13pm and 5:35pm revealed: -She lived at the facility and was responsible to oversee the responsibilities of the home	C 249		

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regarding staff and residents.
-When an order was received, it was her or the Supervisor in Charge's (SIC) responsibility to implement and ensure orders were carried out as ordered.
-Resident #3 did not have a urine sample obtained and sent to the lab for the urinary analysis.
-She was not aware that Resident #3 had an order to obtain a urine sample for a U/A to rule out a UTI.
-If she had been aware of the order, she would have reached out to the facility's contracted laboratory provider as soon as possible, and no later than one business day, who would have come to the facility to collect the sample for Resident #3.

Telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm revealed:
-Resident #3 had a lot of urinary frequency when she assessed him, and she ordered a U/A to rule out a UTI.
-She expected the facility to keep urine kits on hand and obtain a urinary sample when she ordered a urinary analysis, then have the lab pick it up.
-If the facility did not have urine kits, she expected the facility to notify her so she could have some delivered to the facility.
-It was the facility's responsibility to follow up with the lab and ensure Resident #3's U/A was completed as ordered.
-If the resident had decreased his caffeine intake and was no longer complaining of urinary frequency, he probably did not have a UTI, but she would have like to rule it out.

Attempted interview with the SIC on 03/23/22 at

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C 249	Continued From page 12 5:35pm was unsuccessful.	C 249		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family 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 medications for 1 of 3 sampled residents (#1)including a medication used to as a supplement to prevent nerve damage and a medication commonly used to treat seizures. The findings are: Review of Resident #1's current FL-2 dated 02/16/22 and 02/28/22 revealed: -Diagnoses included neurocognitive disorder secondary to traumatic brain injury(TBI) and alcohol use, alcohol use disorder, history of schizophrenia, seizure disorder, and history of multiple TBIs.	C 315		

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C 315	Continued From page 13 -The document had an original signature date of 02/16/22 and a new signature date by the resident's current primary care provider of 02/28/22. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 02/17/22. Review of the facility's Medication Orders policy dated 03/2017 revealed the Administrator would ensure contact with the residents' physician or prescribing practitioner for verification or clarification of orders for medications and treatments if orders were not clear or complete, or if multiple admission forms were received upon admission and orders on the forms were not the same. 1. Review of Resident #1's previous FL-2 dated 02/16/22 revealed there was an order for Rifampin 600mg every morning (used to treat latent tuberculosis (TB)). (TB is a potentially serious infection that primarily affects the lungs.) Review of Resident #1's physician medication orders dated 02/17/22 revealed: -There was an order for Rifampin 600mg every morning to treat latent TB. -There was an order for Pyridoxine 50mg (a supplement used to protect the nervous system) each morning with the Rifampin to prevent neuropathy (a condition that commonly affects the hands and feet causing weakness, numbness, and pain from nerve damage). Review of Resident #1's current FL-2 dated 02/16/22 and 02/28/22 revealed: -There was an order for Rifampin 600mg every morning.	C 315		

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	fcl074052	A. BUILDING: _____ B. WING _____	03/23/2022

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C 315	Continued From page 14 -There was not an order for Pyridoxine 50mg every morning to be taken with the Rifampin. Review of Resident #1's current care plan dated 02/28/22 revealed: -There was an order for Rifampin 600mg every morning. -There was an order for Pyridoxine 50mg every morning. Review of Resident #1's February 2022 medication administration record (MAR) revealed: -There was an entry for Rifampin 600mg every morning. -The Rifampin 600mg was documented as administered daily from 02/18/22-02/28/22. -There was not an entry for Pyridoxine 50mg every morning. -There was no documentation the Pyridoxine 50mg was administered every morning with the Rifampin. Review of Resident #1's March 2022 MAR revealed: -There was an entry for Rifampin 600mg every morning. -The Rifampin 600mg was documented as administered daily from 03/01/22-03/25/22. -There was not an entry for Pyridoxine 50mg every morning. -There was no documentation the Pyridoxine 50mg was administered every morning with the Rifampin. Review of Resident #1's record revealed there was no documentation that the Pyridoxine 50mg order had been clarified with a provider. Observation of Resident #1's medication on hand revealed there was no Pyridoxine 50mg available	C 315		

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C 315	Continued From page 15 to the resident for administration. Telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm revealed: -The pharmacy did not have the FL-2 for Resident #1 dated 02/28/22 on file. -The facility was responsible to fax new FL-2s or medication orders upon receipt to the pharmacy. -It was either the facility's or the pharmacy's responsibility to clarify discrepancies in medication orders upon review and implementation of the orders. -Because the pharmacy did not have the FL-2 dated 02/28/22 on file, it was the facility's responsibility to contact the provider to clarify medication orders for Resident #1 due to conflicting orders. -The facility was expected to administer medications as ordered and send updated orders to the pharmacy to verify accurate MARs for medication administration documentation. -It was important to administer medications as ordered to maintain compliance with rules and protect resident's safety. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/23/22 at 1:50pm revealed: -They had received a copy of Resident #1's physician medication orders dated 02/17/22 and FL-2 02/16/22 for admission to the facility on the same day, 02/17/22. -She was not sure why Resident #1's Pyridoxine had not been filled because it was on the medication orders but thought it might have been missed because it was not on the FL-2. -The pharmacy or the facility should have clarified whether Resident #1 was to receive the Pyridoxine for administration and filled the	C 315		

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C 315	Continued From page 16 medication if it was an accurate order. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/23/22 at 2:05pm revealed: -It was important for Resident #1 to receive the Paroxetine daily as ordered with the Rifampin to treat his latent Tuberculosis (TB). -The Rifampin could cause increased inflammation of nerve endings causing muscle weakness, pain in extremities, and numbness. -Pyridoxine was ordered as a supplement used to protect the nerve endings while on the Rifampin, especially if the resident had a poor nutritional status. -The order for Pyridoxine had been missed by both the facility and the pharmacy and should have been clarified and filled as ordered. -The order for the Pyridoxine was not on Resident #1's FL-2 dated 02/16/22, only on his admission medication orders that had been signed on 02/17/22. -They did not have an FL-2 or medication orders signed on 02/28/22. -She was not sure why the pharmacy or the facility had not called Resident #1's PCP to clarify the order in order to process it and fill the medication as ordered except that it was likely overlooked. -It would have been important for Resident #1 to receive the Pyridoxine as ordered due to the mechanism of action and the side effects that the Rifampin could cause Resident #1. Interview with Resident #1 on 03/23/22 at 8:45am revealed: -He received his medicines on time every day. -The food at the facility was good and he always got plenty to eat.	C 315		

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C 315	Continued From page 17 Observation of Resident #1 during the lunch meal service on 03/23/22 from 1:00pm to 2:20pm revealed: -The resident was served approximately 3 cups of a rice and sausage mixture, 2 cups of iceberg lettuce with ranch dressing, 1 cup of mandarin oranges, 1 biscuit, 8 ounces of milk, 12 ounces of water, 16 ounces of punch, and 8 ounces of coffee. -The resident ate slowly without assistance and consumed 100% of his meal at 2:20pm. Interview with the Supervisor in Charge (SIC) on 03/23/22 at 12:35pm revealed: -She was not aware that Resident #1 was not receiving his Pyridoxine as ordered because she did not realize the medication was only on his admission physician medication orders and not on his admission FL-2. -She had not audited his orders against his MARs and therefore did not clarify or transfer the order to his new FL-2 prior to having his new primary care provider (PCP) sign his FL-2. -She thought she had faxed the admission and new FL-2 along with his admission physician medication orders to the pharmacy and was not sure why the pharmacy had not clarified or filled the order as written. Interview with the Administrator on 03/23/22 at 2:13pm revealed: -It was concerning that Resident #1 Pyridoxine was missed because he was supposed to take the medication along with the Rifampin to treat his latent TB to protect his nervous system. -Resident #1 had never complained of pain and had a very healthy appetite. Telephone interview with the facility's contracted PCP on 03/23/22 at 4:50pm revealed:	C 315		

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C 315	Continued From page 18 -She expected the facility to clarify any confusing or conflicted medication orders and administer medications accurately as ordered. -If the facility had clarified Resident #1's Pyridoxine order she would have ordered the medication to be administered daily with the Rifampin. -The administration of Pyridoxine would have helped to prevent any side effect of neuropathy Resident #1 could ensure from taking the Rifampin. -Resident #1's recent lab work was reassuring, and the facility had not reported the resident complaining of any pain, so the resident should be okay as long as he starts taking the Pyridoxine with the Rifampin. Refer to interview with the Supervisor in Charge (SIC) on 03/23/22 at 12:35pm. Refer to interview with the Administrator on 03/23/22 at 8:55am and 2:13pm. 2. Review of Resident #1's previous FL-2 dated 02/16/22 revealed: -There was an order for Depakote 750mg every morning. (Used to treat seizure disorders.) -There was an order for Depakote 500mg daily at bedtime. -There was a telephone clarification order dated 02/18/22 to correct the Depakote order. -The clarification order was for Depakote 750mg twice daily. Review of Resident #1's physician medication orders dated 02/17/22 revealed: -There was an order for Depakote 500mg twice daily for seizure control. -There was an additional order of Depakote 250mg twice daily for seizure control.	C 315		

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C 315	Continued From page 19 Review of Resident #1's current FL-2 dated 02/16/22 and 02/28/22 revealed: -There was an order for Depakote 750mg every morning. -There was an order for Depakote 500mg daily at bedtime. Review of Resident #1's current care plan dated 02/28/22 revealed: -There was an order for Depakote 500mg twice daily. -There was an order for Depakote 250mg twice daily. Review of an electronically signed physician's order for Resident #1 dated 03/14/22 revealed: -There was an order for Depakote 500mg twice daily. -There was an order for Depakote 250mg twice daily. Observation of Resident #1's medication on hand on 03/23/22 at 6:00pm revealed: -There was Depakote 500mg twice daily filled on 03/15/22 available for administration. -There was Depakote 250mg twice daily filled on 03/15/22 available for administration. Review of Resident #1's March 2022 medication administration record (MAR) revealed: -There was an entry for Depakote 500mg twice daily. -The Depakote 500mg was documented as administered twice daily from 03/01/22-03/25/22. -There was an entry for Depakote 250mg twice daily. -The Depakote 250mg was documented as administered twice daily from 03/01/22-03/25/22. -There was not an entry for Depakote 750mg	C 315		

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every morning per the current FL-2 for 03/01/22-03/14/22.
-There was not an entry for Depakote 500mg daily at bedtime per the current FL-2 for 03/01/22-03/14/22.

Review of Resident #1's record revealed there was no documentation that the Depakote 750mg each morning and 500mg daily at bedtime was clarified against a previous clarification order for Depakote 750mg twice daily.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm revealed:
-The pharmacy received signed orders for Resident #1's Depakote to be administered as 750mg every morning and both 500mg and 750mg at bedtime on 02/16/22; the pharmacy clarified the bedtime order of Depakote due to a differing order on the physician medication orders dated 02/17/22 with Resident #1's medication prescriber at his previous facility on 02/18/22 who had signed the Depakote orders.
-The clarified orders for Resident #1's Depakote on 02/18/22 were 750mg twice daily.
-The pharmacy did not have the FL-2 dated 02/28/22 on file that contained orders for Depakote 750mg each morning and 500mg at bedtime.
-The pharmacy then received updated electronic orders dated 03/14/22 from the facility's contracted mental health provider (MHP) for Resident #1 to receive Depakote 750mg twice daily.
-The facility was responsible to fax new FL-2s or medication orders upon receipt to the pharmacy.
-It was either the facility's or the pharmacy's responsibility to clarify discrepancies in medication orders upon review and

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C 315	Continued From page 21 implementation of the orders. -Because the pharmacy did not have the FL-2 dated 02/28/22 on file, it was the facility's responsibility to contact the provider to clarify the correct Depakote order for Resident #1 due to confusing dosage orders. -The facility was expected to administer medications as ordered and send updated orders to the pharmacy to verify accurate MARs for medication administration documentation. -It was important to administer medications as ordered to maintain compliance with rules and protect resident's safety. Interview with the Supervisor in Charge (SIC) on 03/23/22 at 12:35pm revealed: -She was not aware that Resident #1 had conflicting Depakote orders because she had not audited his orders against his MARs and did not realize the dosage on his admission FL-2 for his Depakote differed from his admission physician medication orders prior to having the new PCP sign his admission FL-2. -She thought she had faxed the FL-2 dated 02/28/22 along with the admission FL-2 and his admission medication list to the pharmacy and was not sure why the pharmacy had not caught the discrepancy to clarify the order. Interview with the Administrator on 03/23/22 at 8:55am and 2:13pm revealed: -She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents. -She did not realize that Resident #1's Depakote orders differed and required clarification. -It was concerning that Resident #1 may not have been receiving an accurately ordered dose of Depakote or that the facility had an un-clarified order on file.	C 315		

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C 315	Continued From page 22 Telephone interview with the facility's contracted mental health (MHP) on 03/23/22 at 3:33pm revealed: -She was not aware that there were un-clarified orders for Resident #1's Depakote. -Per her records, Resident #1 had orders to receive Depakote 750mg every morning and 500mg every night on 02/28/22 signed by his primary care provider (PCP); and he had new orders signed by her on 03/14/22 for Depakote 750mg twice daily. -She was not aware that the admission FL-2 and medication list dated 02/12/22 had orders for Resident #1 to receive Depakote 750mg twice daily from his previous MHP. -The facility had not reported Resident #1 having any increased somnolence and when she assessed the resident on 03/17/22 his assessment was reassuring, so she was not concerned that he had received the higher dose without proper orders. -She expected the facility or the pharmacy to clarify conflicting medication doses and duplicate orders to ensure residents were receiving their medications accurately and as ordered. -It would be concerning if Resident #1 was receiving more Depakote than needed because of possible side effects and tiredness, so she would have to follow up and obtain a Depakote level on him to ensure he wasn't getting too much. Refer to interview with the Supervisor in Charge (SIC) on 03/23/22 at 12:35pm. Refer to interview with the Administrator on 03/23/22 at 8:55am and 2:13pm. Interview with the Supervisor in Charge (SIC) on	C 315		

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C 315	Continued From page 23 03/23/22 at 12:35pm revealed: -When a resident's primary care provider (PCP) wrote a new medication order, the PCP would either send the order electronically to the pharmacy or she would fax the order to the pharmacy upon receipt from the PCP. -Once the pharmacy received the order, they would fill the medication prescription and then deliver it to the facility along with a generated MAR to document the administration of the medication. -She was responsible to perform medication cart audits once weekly to ensure the medications on hand matched the resident's MARs. -There was no process in place to audit resident's orders against the MAR to ensure the MARs were accurate because she had not thought to do it. Interview with the Administrator on 03/23/22 at 8:55am and 2:13pm revealed: -She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents. -When a medication order was received, it was to be immediately faxed to the pharmacy so they could process and fill the order, then deliver it to the facility along with a generated MAR to document administration. -It was important to send medications orders immediately to the pharmacy so the facility could ensure resident medications were on hand to be administered as ordered. -It was the SIC's responsibility to ensure medications were on hand as ordered and to ensure medications orders were accurate on the residents' MARs.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration	C 330		

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C 330	Continued From page 24 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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered and in accordance with the facility's policies for 1 of 3 sampled residents (#2) including errors with obtaining finger stick blood sugars (FSBS) and administration of sliding scale insulin. The findings are: Review of the facility's Medication Administration Competency policy dated 03/2017 revealed: -Medications were to be administered in the proper procedure to administer. -Ensure the right medication, amount, resident, and time are administered as prescribed. Review of Resident #2's current FL-2 dated 03/08/22 revealed: -Diagnoses included schizoaffective disorder, bipolar, hypertension, and type 2 diabetes with long-term use of insulin. -There was an entry under medications to "see attached" for medication orders. -Attached to the FL-2 was a hospital after visit summary from a hospitalization from 11/26/21-03/09/22 with medication orders as	C 330		

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follows:
-There was an order for finger stick blood sugars (FSBS) to test blood sugars three times daily before meals, before bedtime, and as needed for symptoms of high or low blood sugar.
-There was an order for insulin regular human 100 units/ml (a short acting insulin used to regulate blood sugars) to be administered with FSBS per sliding scale; 51-70 give juice/crackers, 71-150 give 0 units, 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, greater than 400 give 12 units.

Review of Resident #2's March 2022 medication administration record (MAR) revealed:
-There was an entry for finger stick blood sugars (FSBS) to test blood sugars three times daily before meals, before bedtime, and as needed for symptoms of high or low blood sugar.
-The FSBS were documented as administered three times daily before meals from 03/10/22-03/25/22 using initials, but there was no documentation of FSBS results or the FSBS being completed before bedtime.
-There was an entry for insulin regular human 100 units/ml to be administered with FSBS per sliding scale; 51-70 give juice/crackers, 71-150 give 0 units, 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, greater than 400 give 12 units.
-There was no documentation FSBS results or of insulin regular human administered per sliding scale.

Review of a March 2022 Blood Glucose Journal for Resident #2 revealed:
-The document had columns for breakfast, lunch, dinner, and night, each with two sub-columns to

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document the FSBS result and the amount of insulin administered for each time frames and rows crossing each column for each day of the month.
-There was also a column on the document for "other" as well as a comment section out to the side.
-On 03/10/22, FSBS were documented as 108 at dinner and 181 at bedtime; it was documented under comments that 2 units of insulin were administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/11/22, FSBS were documented as 88 at breakfast, 102 at lunch, 155 at dinner, and there was not a FSBS documented at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale.
-On 03/12/22, FSBS were documented as 74 at breakfast, 108 at lunch, 197 at dinner with 2 units of insulin administered, and 257 at bedtime; it was documented under comments that 6 units of insulin was administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/13/22, FSBS were documented as 115 at breakfast, 129 at lunch, 196 at dinner, and a refusal of FSBS at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale.
-On 03/14/22, FSBS were documented as 94 at breakfast, 108 at lunch, 222 at dinner, and 66 at bedtime; it was documented under comments that 4 units of insulin were administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/15/22, FSBS were documented as 104 at breakfast, 85 at lunch, 235 at dinner, and there

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was no documentation of a FSBS at bedtime; it was documented under comments that 4 units of insulin were administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/16/22, FSBS were documented as 133 at breakfast, 162 at lunch, 260 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 6 units of insulin were administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/17/22, FSBS were documented as 126 at breakfast, 287 at lunch, 298 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 6 units of insulin were administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/18/22, FSBS were documented as 126 at breakfast, 145 at lunch, 354 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 10 units of insulin were administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/19/22, FSBS were documented as 144 at breakfast, 128 at lunch, 106 at dinner, and there was no documentation of a FSBS at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale.
-On 03/20/22, FSBS were documented as 173 at breakfast, 217 at lunch, 290 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 6 units of insulin were administered per sliding scale, but

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there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/21/22, FSBS were documented as 143 at breakfast, 108 at lunch, 161 at dinner, and there was no documentation of a FSBS at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale.
-On 03/22/22, FSBS were documented as 99 at breakfast, 182 at lunch, 221 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 4 units of insulin were administered per sliding scale, but there was no documentation of what time and type of insulin was administered in relation to each FSBS.
-On 03/23/22, FSBS were documented as 74 at breakfast; there was no documentation of whether insulin was or was not administered per sliding scale.

Interview with the Supervisor in Charge (SIC) on 03/23/22 at 10:55am revealed:
-She rarely administered medications to Resident #2 and could not remember if or when she had last administered medications to the resident.
-It was important to accurately administer resident's MAR medications per the right resident, medication, dose, time, and route.

Interview with the Administrator on 03/23/22 at 8:55am and 10:55am revealed:
-She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents, including medication administration.
-She had employees that came in during the day from 7:00am to 7:00pm to assist her in caring for the residents and maintaining the home.
-She did not realize the order stated to check

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C 330	Continued From page 29 Resident #2's FSBS before bedtime, she thought she was only supposed to check it three times daily before meals. -She did not realize how confusing her documentation was on Resident #2's MAR and Blood Glucose Log in that it was hard to tell what she had administered and when as compared to his orders. -She should have administered and documented on the MAR the FSBS results and what was administered, at what time, and in what site per sliding scale for Resident #2 as required to show accuracy of administration of his medications as compared to his orders. Telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm revealed: -The facility was expected to administer medications as ordered. -It was important to administer medications and document them as ordered to maintain compliance with rules and protect resident's safety. Telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm revealed: -She had not yet assessed or seen Resident #2 yet but expected his FSBS and insulin to be administered as ordered. -It was important to Resident #2's FSBS and insulin orders to be carried out as ordered to reflect an accurate picture of the resident's health for her to accurately assess him and guide his care. -If the resident did not receive his insulin as needed or as ordered, he could have unstable blood sugars. -If Resident #2 continued to have blood sugars	C 330		

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C 330	Continued From page 30 that remained high from lack of FSBS or inaccurate insulin administration could lead to chronic kidney disease, heart complications, blindness, urinary tract infections, and an overall decline in his health. -It was concerning that Resident #2 was not receiving his FSBS and insulin as ordered because it prevented her from being able to stabilize him and accurately assess him to manage his blood sugars.	C 330		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure staff documented on the medication administration records (MARs) the administration of medications immediately following the administration and not pre-chart administration of medications for 3 of 3 sampled residents (#1, #2, #3). The findings are:	C 341		

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Review of the facility's Medication Administration policy dated 03/2017 revealed the staff person administering medication was responsible for charting the drug immediately after administration on the resident's medication administration record (MAR).

1. Review of Resident #1's current FL-2 dated 02/16/22 and 02/28/22 revealed:
-Diagnoses included neurocognitive disorder secondary to traumatic brain injury(TBI) and alcohol use, alcohol use disorder, history of schizophrenia, seizure disorder, and history of multiple TBIs.
-The document had an original signature date of 02/16/22 and a new signature date by the resident's current primary care provider of 02/28/22.
-There was an order for Depakote 750mg (used for seizures and mood disorders) every morning.
-There was an order for Depakote 500mg daily at bedtime.
-There was an order for Keppra 1000mg (used for seizures) every morning.
-There was an entry for Keppra 500mg every evening at bedtime.
-There was an order for Miralax 17gm with 8 ounces of water (for constipation) every morning.
-There was an order for Rifampin 600mg (used to treat latent tuberculosis (TB))every morning.
-There was an order for Sodium Chloride 2000mg (used as a dietary supplement) twice daily.

Review of Resident #1's March 2022 MAR revealed:
-There was an entry for Depakote 500mg twice daily.
-The Depakote 500mg was documented as administered daily from 03/01/22-03/25/22.
-There was an entry for Depakote 250mg twice

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daily.
-The Depakote 250mg was documented as administered daily from 03/01/22-03/25/22.
-There was an entry for Keppra 1000mg every morning for seizures.
-The Keppra 1000mg was documented as administered daily from 03/01/22-03/25/22.
-There was an entry for Keppra 500mg every evening at bedtime.
-The Keppra 500mg was documented as administered daily from 03/01/22-03/25/22.
-There was an entry for Miralax 17gm with 8 ounces of water every morning.
-The Miralax 17gm was documented as administered daily from 03/01/22-03/25/22.
-There was an entry for Rifampin 600mg every morning.
-The Rifampin 600mg was documented as administered daily from 03/01/22-03/25/22.
-There was an entry for Sodium Chloride 2000mg twice daily.
-The Sodium Chloride 2000mg was documented as administered daily from 03/01/22-03/25/22.
-The review of the resident's MAR took place on 03/23/22 meaning all medications had been pre-charted as administered for 03/24/22-03/25/22.

Refer to interview with the Administrator on 03/23/22 at 8:55am and 10:55am.

Refer to interview with the Supervisor in Charge (SIC) and Administrator on 03/23/22 at 10:55am.

Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm.

Refer to telephone interview with the facility's contracted mental health provider (MHP) on

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C 341	Continued From page 33 03/23/22 at 3:33pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm. 2. Review of Resident #2's current FL-2 dated 03/08/22 revealed: -Diagnoses included schizoaffective disorder, bipolar, hypertension, and type 2 diabetes with long-term use of insulin. -There was an entry under medications to "see attached" for medication orders. -Attached to the FL-2 was a hospital after visit summary from a hospitalization from 11/26/21-03/09/22 with medication orders as follows: -There was an order for Claritin 10mg (used to treat seasonal allergies) daily. -There was an order Glipizide 5mg (used to help stabilize blood sugars) every morning before breakfast. -There was an order for Losartan 100mg (used to treat high blood pressure) daily. -There was an order for Metoprolol ER 100mg (used to treat high blood pressure) daily. -There was an order for Atorvastatin 20mg (used to treat high cholesterol) daily. -There was an order for Vitamin D3 2000 units (used as a dietary supplement) daily. -There was an order for Haloperidol 2mg/ml (used to treat mood disorders) take 2mg each morning. -There was an order for Haloperidol 2mg/ml take 4mg before bedtime daily. -There was an order for Novolin R 100 units/ml (long acting insulin used to treat high blood sugars) take 27 units twice daily. -There was an order for Valproic Acid 250mg/5ml (used to treat mood disorders) take 25ml twice	C 341		

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C 341	Continued From page 34 daily. -There was an order for Zyprexa 20mg (used to treat mood disorders) take twice daily. -There was an order for Metformin 1000mg (used to help stabilize blood sugars) take twice daily. -There was an order for Clonazepam 0.5mg (used to treat mood disorders) take three times daily. -There was an order for finger stick blood sugars (FSBS) to test blood sugars three times daily before meals, before bedtime, and as needed for symptoms of high or low blood sugar. Review of Resident #2's March 2022 MAR revealed: -There was an entry for Claritin 10mg daily. -The Claritin 10mg was documented as administered daily from 03/10/22-03/25/22. -There was an entry Glipizide 5mg every morning before breakfast. -The Glipizide 5mg was documented as administered daily from 03/10/22-03/25/22. -There was an entry for Losartan 100mg daily. -The Losartan 100mg was documented as administered daily from 03/10/22-03/25/22. -There was an entry for Metoprolol ER 100mg daily. -The Metoprolol 100mg was documented as administered daily from 03/10/22-03/25/22. -There was an entry for Atorvastatin 20mg daily. -The Atorvastatin 20mg was documented as administered daily from 03/10/22-03/25/22. -There was an entry for Vitamin D3 2000 units daily. -The Vitamin D3 2000 units was documented as administered daily from 03/10/22-03/25/22. -There was an entry for Haloperidol 2mg/ml take 2mg each morning. -The Haloperidol 2mg was documented as administered daily from 03/10/22-03/25/22.	C 341		

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C 341	Continued From page 35 -There was an entry for Haloperidol 2mg/ml take 4mg before bedtime daily. -The Haloperidol 4mg was documented as administered daily from 03/10/22-03/25/22. -There was an entry for Novolin R 100 units/ml take 27 units twice daily. -The Novolin R 27 units was documented as administered twice daily from 03/10/22-03/25/22. -There was an entry for Valproic Acid 250mg/5ml take 25ml twice daily. -The Valproic Acid 25ml was documented as administered twice daily from 03/10/22-03/25/22. -There was an entry for Zyprexa 20mg take twice daily. -The Zyprexa 20mg was documented as administered twice daily from 03/10/22-03/25/22. -There was an entry for Metformin 1000mg take twice daily. -The Metformin 1000mg was documented as administered twice daily from 03/10/22-03/25/22. -There was an entry for Clonazepam 0.5mg take three times daily. -The Clonazepam 0.5mg was documented as administered three times daily from 03/10/22-03/25/22. -There was an entry for finger stick blood sugars (FSBS) to test blood sugars three times daily before meals, before bedtime, and as needed for symptoms of high or low blood sugar. -The FSBS were documented as administered three times daily before meals from 03/10/22-03/25/22. -The review of the resident's MAR took place on 03/23/22 meaning all medications had been pre-charted as administered for 03/24/22-03/25/22. Refer to interview with the Administrator on 03/23/22 at 8:55am and 10:55am.	C 341		

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C 341	Continued From page 36 Refer to interview with the Supervisor in Charge (SIC) and Administrator on 03/23/22 at 10:55am. Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm. Refer to telephone interview with the facility's contracted mental health provider (MHP) on 03/23/22 at 3:33pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm. 3. Review of Resident #3's current FL-2 dated 12/08/22 revealed: -Diagnoses included schizoaffective disorder, bipolar, neurocognitive disorder, history of anxiety, hyperlipidemia, constipation, seborrheic dermatitis, and type 2 diabetes. -There was an order for Abilify 5mg (used to treat mood disorders) every morning. -There was an order for Lipitor 20mg (used to treat high cholesterol) every morning. -There was an order for Imdur 30mg (used to treat heart failure or pain and esophageal spasms) every morning. -There was an order for Lithium 300mg (used to treat mood disorders) every morning. -There was an order for Lithium 600mg every evening at bedtime. -There was an order for Bisacodyl 5mg (used to treat constipation) every evening at bedtime. -There was an order for Metformin 1000mg (used to help regulate blood sugars) twice daily with breakfast and supper. -There was an order for Zyprexa 5mg (used to treat mood disorders) three times daily. -There was an order for Miralax 17gm with 8	C 341		

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ounces of liquid (used to treat constipation) every morning.
-There was an order for Eucerine cream twice daily (for dry skin) to hands.
-There was an order for Urea cream 20% twice daily (for dry/cracked skin) to heels.

Review of a physician's order for Resident #3 dated 02/15/22 revealed:
-There was an order to discontinue Zyprexa 5mg three times daily and start Zyprexa 15mg daily with supper.

Review of Resident #3's March 2022 MAR revealed:
-There was an entry for Abilify 5mg every morning.
-The Abilify 5mg was documented at administered daily from 03/01/22-03/25/22.
-There was an entry for Lipitor 20mg every morning.
-The Lipitor 20mg was documented at administered daily from 03/01/22-03/25/22.
-There was an entry for Imdur 30mg every morning.
-The Imdur 30mg was documented at administered daily from 03/01/22-03/25/22.
-There was an entry for Lithium 300mg every morning.
-The Lithium 300mg was documented at administered daily from 03/01/22-03/25/22.
-There was an entry for Lithium 600mg every evening at bedtime.
-The Lithium 600mg was documented at administered daily from 03/01/22-03/25/22.
-There was an entry for Bisacodyl 5mg every evening at bedtime.
-The Bisacodyl 5mg was documented as administered daily from 03/01/22-03/25/22.
-There was an entry for Metformin 1000mg twice

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daily with breakfast and supper.
-The Metformin 1000mg was documented at administered twice daily from 03/01/22-03/25/22.
-There was an entry for Zyprexa 15mg daily.
-The Zyprexa 15mg was documented at administered daily from 03/01/22-03/25/22.
-There was an entry for Miralax 17gm with 8 ounces of liquid every morning.
-The Miralax 17gm was documented at administered daily from 03/01/22-03/25/22.
-There was an entry for Eucerine cream twice daily to hands.
-The Eucerine cream was documented as administered twice daily from 03/01/22-03/25/22.
-There was an entry for Urea cream 20% twice daily to heels.
-The Urea cream 20% was documented at administered twice daily from 03/01/22-03/25/22.
-The review of the resident's MAR took place on 03/23/22 meaning all medications had been pre-charted as administered for 03/24/22-03/25/22.

Refer to interview with the Administrator on 03/23/22 at 8:55am and 10:55am.

Refer to interview with the Supervisor in Charge (SIC) and Administrator on 03/23/22 at 10:55am.

Refer to telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm.

Refer to telephone interview with the facility's contracted mental health provider (MHP) on 03/23/22 at 3:33pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm.

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(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 341	Continued From page 39 Interview with the Administrator on 03/23/22 at 8:55am and 10:55am revealed: -She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents. -She had employees that came in during the day from 7:00am to 7:00pm to assist her in caring for the residents and maintaining the home. -She had pre-charted the medications for Residents #1, #2, and #3 since the first week of February 2022. -She knew she was not supposed to pre-chart medications but did it because her hands would swell and hurt since her hospitalization and it was sometimes difficult to write and saved her time. -She would pre-chart medication administration for the residents one week at a time. -She knew pre-charting was wrong and having a pain in her hands was not an excuse. -She was normally the only person to administer medications to the residents, but sometimes the Supervisor in Charge (SIC) would come and administer medications to residents. -Pre-charting medication administration could lead to medication errors that could be detrimental to the residents' safety. Interview with the Supervisor in Charge (SIC) and the Administrator on 03/23/22 at 10:55am revealed: -It was important to accurately document on a resident's MAR to ensure accuracy of medication administration to the right resident, medication, dose, time, and route. -Accurately documenting medication administration in real time could prevent medication errors that could be detrimental to the residents' safety. -Pre-documentation of medication administration	C 341		

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C 341	Continued From page 40 should not be done and should be considered a medication error that was reported to a resident's primary care provider (PCP). Telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm revealed: -The facility was expected to administer medications as ordered and send updated orders to the pharmacy to verify accurate MARs for medication administration documentation. -It was important to administer medications and document them as ordered to maintain compliance with rules and protect resident's safety. Telephone interview with the facility's contracted MHP on 03/23/22 at 3:33pm revealed: -It was concerning that the Administrator was pre-charting her medication administration on residents' MARs because medications should only be charted in real time when administered to ensure accuracy of administration and MAR documentation. -Pre-charting medication administration could lead to medication errors such as missed medication administration due to already being documented, possible diversion, and other medication errors along with having an inaccurate MAR. Telephone interview with the facility's contracted PCP on 03/23/22 at 4:50pm revealed: -It was concerning that the Administrator was pre-charting medication administration on resident MARs. -It was important for medications to be administered and documented accurately as ordered to protect resident safety. -Pre-charting medications could lead to	C 341		

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C 341	Continued From page 41 medication errors or inaccurate narcotic counts.	C 341		
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). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medication administration records (MARs) were complete and accurate for 1 of 3 residents sampled (#2) related to obtaining finger stick blood sugars (FSBS) and administration of sliding scale insulin. The findings are:	C 342		

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C 342	Continued From page 42	C 342		

Review of the facility's Medication Administration Competency policy dated 03/2017 revealed:
-Medications should be recorded on the medication administration record (MAR).
-Staff were to record the dosage and time of administration on the MAR as well as if the resident refuses to take a regularly scheduled medication.
-The MAR was a permanent part of the individual record.
-The record would show day, time, medication, dosage, and staff member that administered medications.

Review of Resident #2's current FL-2 dated 03/08/22 revealed:
-Diagnoses included schizoaffective disorder, bipolar, hypertension, and type 2 diabetes with long-term use of insulin.
-There was an entry under medications to "see attached" for medication orders.
-Attached to the FL-2 was a hospital after visit summary from a hospitalization from 11/26/21-03/09/22 with medication orders as follows:
-There was an order for finger stick blood sugars (FSBS) to test blood sugars three times daily before meals, before bedtime, and as needed for symptoms of high or low blood sugar.
-There was an order for insulin regular human 100 units/ml to be administered with FSBS per sliding scale; 51-70 give juice/crackers, 71-150 give 0 units, 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, greater than 400 give 12 units.

Review of Resident #2's March 2022 medication administration record (MAR) revealed:
-There was an entry for finger stick blood sugars

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C 342	Continued From page 43 (FSBS) to test blood sugars three times daily before meals, before bedtime, and as needed for symptoms of high or low blood sugar. -The FSBS were documented as administered three times daily before meals from 03/10/22-03/25/22 but there was no documentation of FSBS before bedtime. -There was an entry for insulin regular human 100 units/ml to be administered with FSBS per sliding scale; 51-70 give juice/crackers, 71-150 give 0 units, 151-200 give 2 units, 201-250 give 4 units, 251-300 give 6 units, 301-350 give 8 units, 351-400 give 10 units, greater than 400 give 12 units. -There was no documentation FSBS results or of insulin regular human administered per sliding scale. -There was an entry for Novolin R 100 units/ml (long acting insulin used to treat high blood sugars) take 27 units twice daily. -The Novolin R 27 units was documented as administered twice daily from 03/10/22-03/25/22 but there was no documentation of what site the insulin was administered on the resident's body. Review of a March 2022 Blood Glucose Journal for Resident #2 revealed: -The document had columns for breakfast, lunch, dinner, and night, each with two sub-columns to document the FSBS result and the amount of insulin administered for each time frames and rows crossing each column for each day of the month. -There was also a column on the document for "other" as well as a comment section out to the side. -On 03/10/22, FSBS were documented as 108 at dinner and 181 at bedtime; it was documented under comments that 2 units of insulin were administered per sliding scale, but there was no	C 342		

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C 342	Continued From page 44 documentation of what type of insulin, what site, or what time the insulin was administered. On 03/11/22, FSBS were documented as 88 at breakfast, 102 at lunch, 155 at dinner, and there was not a FSBS documented at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale. On 03/12/22, FSBS were documented as 74 at breakfast, 108 at lunch, 197 at dinner with 2 units of insulin administered, and 257 at bedtime; it was documented under comments that 6 units of insulin were administered per sliding scale, but there was no documentation of what type of insulin, what site, or what time the insulin was administered. - On 03/13/22, FSBS were documented as 115 at breakfast, 129 at lunch, 196 at dinner, and a refusal of FSBS at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale. -On 03/14/22, FSBS were documented as 94 at breakfast, 108 at lunch, 222 at dinner, and 66 at bedtime; it was documented under comments that 4 units of insulin were administered per sliding scale, but there was no documentation of what type of insulin, what site, or what time the insulin was administered. -On 03/15/22, FSBS were documented as 104 at breakfast, 85 at lunch, 235 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 4 units of insulin were administered per sliding scale, but there was no documentation of what type of insulin, what site, or what time the insulin was administered. -On 03/16/22, FSBS were documented as 133 at breakfast, 162 at lunch, 260 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 6 units of insulin were administered per sliding scale, but	C 342		

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C 342	Continued From page 45 there was no documentation of what type of insulin, what site, or what time the insulin was administered. -On 03/17/22, FSBS were documented as 126 at breakfast, 287 at lunch, 298 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 6 units of insulin were administered per sliding scale, but there was no documentation of what type of insulin, what site, or what time the insulin was administered. -On 03/18/22, FSBS were documented as 126 at breakfast, 145 at lunch, 354 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 10 units of insulin were administered per sliding scale, but there was no documentation of what type of insulin, what site, or what time the insulin was administered. -On 03/19/22, FSBS were documented as 144 at breakfast, 128 at lunch, 106 at dinner, and there was no documentation of a FSBS at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale. -On 03/20/22, FSBS were documented as 173 at breakfast, 217 at lunch, 290 at dinner, and there was no documentation of a FSBS at bedtime; it was documented under comments that 6 units of insulin were administered per sliding scale, but there was no documentation of what type of insulin, what site, or what time the insulin was administered. -On 03/21/22, FSBS were documented as 143 at breakfast, 108 at lunch, 161 at dinner, and there was no documentation of a FSBS at bedtime; there was no documentation of whether insulin was or was not administered per sliding scale. -On 03/22/22, FSBS were documented as 99 at breakfast, 182 at lunch, 221 at dinner, and there was no documentation of a FSBS at bedtime; it	C 342		

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C 342	Continued From page 46 was documented under comments that 4 units of insulin were administered per sliding scale, but there was no documentation of what type of insulin, what site, or what time the insulin was administered. -On 03/23/22, FSBS were documented as 74 at breakfast; there was no documentation of whether insulin was or was not administered per sliding scale. Interview with the Administrator on 03/23/22 at 10:55am revealed: -She did not realize the order stated to check Resident #2's FSBS before bedtime. -She did not realize how confusing her documentation was and that it should have been accurately documented on the MAR. -She should have documented on the MAR the FSBS and what was administered, at what time, and in what site per sliding scale for Resident #2 as required to show accuracy of administration. Interview with the Supervisor in Charge (SIC) and the Administrator on 03/23/22 at 10:55am revealed: -It was important to accurately document on a resident's MAR to ensure accuracy of medication administration to the right resident, medication, dose, time, and route. -Accurately documenting medication administration in real time could prevent medication errors that could be detrimental to the residents' safety. Interview with the Administrator on 03/23/22 at 8:55am and 10:55am revealed: -She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents. -She had employees that came in during the day	C 342		

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C 342	Continued From page 47 from 7:00am to 7:00pm to assist her in caring for the residents and maintaining the home. -When a medication order was received, it was to be immediately faxed to the pharmacy so they could process and fill the order, then deliver it to the facility along with a generated MAR to document administration. -It was important to send medications orders immediately to the pharmacy so the facility could ensure resident medications were on hand to be administered as ordered. -It was the SIC's responsibility to ensure medications were on hand as ordered and to ensure medications orders were accurate on the residents' MARs. -Having an inaccurate MAR could lead to medication administration errors that could be detrimental to the residents' safety. Telephone interview with a pharmacy technician at the facility's contracted pharmacy provider on 03/23/22 at 4:30pm revealed: -The pharmacy was responsible to generate MARs for the facility based on the orders the pharmacy had on file for each resident. -The facility was responsible to fax new FL-2s or medication orders upon receipt to the pharmacy. -The facility was expected to administer medications as ordered and send updated orders to the pharmacy to verify accurate MARs for medication administration documentation or clarification if necessary. -It was important to administer medications and document them accurately as ordered to maintain compliance with rules and protect resident's safety. Telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm revealed:	C 342		

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C 342	Continued From page 48 -She had not yet assessed or seen Resident #2 yet but expected his FSBS and insulin to be administered as ordered and documented on his MAR accurately. -It was important that Resident #2's FSBS and insulin orders to be carried out as ordered and documented accurately to reflect an accurate picture of the resident's health for her to accurately assess him and guide his care.	C 342		
C 612	10A NCAC 13G .1701 (c) Infection Prevention & Control Program (temp) 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by:	C 612		

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C 612	Continued From page 49 Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) during the global pandemic of COVID-19 were implemented and maintained to provide protections and reduce the risk of transmission and infection to residents regarding proper use of face masks and visitor, resident, and staff screening. The findings are: Review of the Centers for Disease Control (CDC) Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic dated 02/02/22 revealed facilities shall implement source control which includes use of respirators or well-fitting facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22: -NCDHHS recommends facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure. -Facilities shall continue to screen all who enter for signs and symptoms of COVID-19. Review of the facility's Infection Control Procedures policy revealed: -The policy and procedure would be updated as needed to reflect the guidelines and recommendations of the CDC, local health	C 612		

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C 612	Continued From page 50	C 612		

department (LHD), and the NCDHHS.
-All who entered the facility would be screened for signs and symptoms of COVID-19 to include a temperature check.
-All who entered should have a face covering or mask covering the mouth and nose.
-Instructional signage should be posted throughout the facility with proper visitor education on COVID-19 signs and symptoms, infection control precautions, and other applicable home practices such as the use of a face mask and hand hygiene.
-Staff should use appropriate personal protective equipment (PPE) and encourage source control from residents, staff and visitors.

Review of the facility's COVID-19 policy and procedure manual revealed:
-Infection prevention and control strategies were to be adopted using administrative controls, safe work practices, and the use of PPE to prevent exposures.
-Staff were always to wear a cloth face covering at minimum when around co-workers or others.
-Staff and visitors were to be screened for symptoms of COVID-19 and with a temperature check for fever upon entry to the facility.
-Residents were to be evaluated daily for symptoms of COVID-19 or fever.

1. Observation of facility entrance on 03/23/22 at 8:15am revealed:
-There was no signage posted at the entrance of the facility regarding infection prevention, screening for COVID-19, or not to visit if respiratory symptoms were present.
-There were no supplies at the front entrance for visitors to screen for COVID-19 or obtain PPE.
-The personal care aide (PCA) admitting a surveyor to the facility did not screen the surveyor

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C 612	Continued From page 51	C 612		

with questions regarding COVID-19 or obtain a temperature.
-The PCA was not wearing a procedure mask; the surveyor was wearing a procedure mask covering her mouth and nose.

Interview with the PCA on 03/23/22 at 9:28am revealed he should have screened the surveyor upon entrance to the facility, but he forgot.

Interview with the Administrator on 03/23/22 at 8:55am revealed:
-She lived at the facility and was responsible to oversee the responsibilities of the home regarding staff and residents.
-She had employees that came in during the day from 7:00am to 7:00pm to assist her in caring for the residents and maintaining the home.

Interview with the Supervisor in Charge (SIC) and the Administrator on 03/23/22 at 9:28am revealed:
-The residents could have visitors but there were not many visitors that came to the facility.
-Staff were expected to screen any visitor that came to the facility using COVID-19 screening questions and obtaining a temperature, then having the visitor sign in using a visitor log.
-The PCA should have screened the surveyor but he had forgotten, they did not know why.

Observation of the surveyor on 03/23/22 at 9:28am revealed the SIC and Administrator screened the surveyor upon being made aware she had not been screened upon entry to ensure she was not at risk of infection transmission to the staff and residents at that time.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on

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L & C FAMILY CARE HOME #2	4224 WASHINGTON STREET AYDEN, NC 28513

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C 612	Continued From page 52 03/23/22 at 4:50pm. 2. Observation of the screening station located in the kitchen on 03/23/22 at 9:28am revealed there was only a visitor screening log; there was not a resident or staff screening log or documentation of daily screening available. Interview with a resident on 03/23/22 at 1:35pm revealed the staff did not screen him for COVID-19 by obtaining his temperature or asking him questions unless he was feeling ill. Interview with the Supervisor in Charge (SIC) and the Administrator on 03/23/22 revealed: -The facility was no longer requiring screening of residents or staff at that time. -The were not instructed by their local health department to discontinue screening of residents and staff but thought that because community guidance had relaxed, and all staff and residents were vaccinated and boosted against COVID-19 they longer had to screen. -The facility stopped screening residents and staff in January 2022. Refer to interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm. 3. Intermittent observations of 2 of 3 staff on 03/23/22 from 8:15am to 9:23am revealed staff were not wearing procedure masks and 1 of 3 staff members was wearing a procedure mask that did not cover her nose and she would pull the mask down below her chin to speak to others. Interview with the Supervisor in Charge (SIC) and the Administrator on 03/23/22 revealed: -The facility was no longer requiring the use of	C 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	fcl074052	A. BUILDING: _____ B. WING _____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 612	Continued From page 53 procedure masks for staff at that time. -The were not instructed by their local health department to discontinue the use of procedure masks but thought that because community guidance had relaxed, and all staff and residents were vaccinated and boosted against COVID-19 they longer had to use masks unless they were in outbreak status. -The facility stopped using procedure masks in January 2022 and had never had a staff member or resident positive for COVID-19. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm. _____ Telephone interview with the facility's contracted primary care provider (PCP) on 03/23/22 at 4:50pm revealed: -She expected the facility to screen visitors, residents and staff daily per CDC guidelines. -She always expected facility staff to wear a mask in the facility and for residents to wear a mask when feeling ill or when going outside of the facility. -It was important for the facility to maintain current CDC infection prevention guidelines to identify and prevent the spread of COVID-19 for resident and staff safety. -It was concerning that the facility had not been screening visitors, staff, or residents as directed because the risk of spreading COVID-19 was always present and needed to be prevented.	C 612		