

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL061063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/15/2022
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

PANDORA FAMILY CARE HOME

**924 HOBBS STREET
CLAYTON, NC 27520**

(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 December 15, 2022.	C 000	10A NCAC 13G .0904(d) (3)(H) Nutrition and Food Service.	1/02/23
C 280	10A NCAC 13G .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure water and other beverages were served at mealtimes according to the menu for 3 of 3 sampled residents(#1, #2, #3). The findings are: 1. Review of Resident #1's FL-2 dated 02/09/22 revealed diagnoses included schizophrenia, and hypertension. Review of the breakfast menu for 12/15/22 revealed: -There was an entry for 8 oz low-fat milk. -There was an entry for 8 oz orange juice. -There was an entry for 8 oz water. Observation of Resident #1's breakfast meal on 12/15/22 at 8:15am revealed: -The resident was not served low-fat milk. -The resident was not served orange juice. -The resident was not served water.	C 280	All employees at Pandora FCH have been educated and menus have been revised. All meals will be served with a side of water and other beverages including tea, tomatoe juice, or orange juice. Despite resident refusal, water and other beverages shall be served with each meal. The Administrator will be in charge of enforcing this rule.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

June Osuru

TITLE

Administrator

(X6) DATE

1/02/23

STATE FORM

6899

T3W011

If continuation sheet 1 of 10

Reviewed and Acknowledged 01/17/23 Sharon Melvin

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C 280	Continued From page 1 -Resident #1 was served tea. Review of the lunch menu for 12/15/22 revealed: -There was an entry for 6 oz tomato juice. -There was an entry for 8 oz water. Observation of Resident #1's lunch meal on 12/15/22 at 12:10pm revealed: -The resident was not served tomato juice. -The resident was not served water. -Resident #1 was served tea. Observation of the refrigerator on 12/15/22 at 9:30am revealed: -There was a half gallon of orange juice in the refrigerator. -There was a half gallon of milk in the refrigerator. Refer to interview with the medication aide (MA) on 12/15/22 at 4:06pm. Refer to telephone interview with the Owner/Administrator on 12/15/22 at 4:20pm. 2. Review of Resident #2's FL-2 dated 07/28/22 revealed diagnoses included schizoaffective disorder bipolar type, frequent falls, stroke, hypotension, and thrombocytopenia. Review of the breakfast menu for 12/15/22 revealed: -There was an entry for 8 oz low-fat milk. -There was an entry for 8 oz orange juice. -There was an entry for 8 oz water. Observation of Resident #2's breakfast meal on 12/15/22 at 8:15am revealed: -The resident was not served low-fat milk. -The resident was not served orange juice. -The resident was not served water.	C 280			

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C 280	Continued From page 2 -Resident #2 was served tea. Review of the lunch menu for 12/15/22 revealed: -There was an entry for 6 oz tomato juice. -There was an entry for 8 oz water. Observation of Resident #2's lunch meal on 12/15/22 at 12:10pm revealed: -The resident was not served tomato juice. -The resident was not served wter -Resident #2 was served tea. Observation of the refrigerator on 12/15/22 at 9:30am revealed: -There was a half gallon of orange juice in the refrigerator. -There was a half gallon of milk in the refrigerator. Refer to interview with the medication aide (MA) on 12/15/22 at 4:06pm. Refer to telephone interview with the Owner/Administrator on 12/15/22 at 4:20pm. 3. Review of Resident #3's FL-2 dated 05/11/22 revealed diagnoses included schizophrenia and hyperlipidemia. Review of the breakfast menu for 12/15/22 revealed: -There was an entry for 8 oz low-fat milk. -There was an entry for 8 oz orange juice. -There was an entry for 8 oz water. Observation of Resident #3's breakfast meal on 12/15/22 at 8:15am revealed: -The resident was not served low-fat milk. -The resident was not served orange juice. -The resident was not served water. -Resident #3 was served tea.	C 280		

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C 280	Continued From page 3 Observation of Resident #3's lunch meal on 12/15/22 at 12:10pm revealed the resident was out of the facility at a day program. Observation of the refrigerator on 12/15/22 at 9:30am revealed: -There was a half gallon of orange juice in the refrigerator. -There was a half gallon of milk in the refrigerator. Refer to interview with the medication aide (MA) on 12/15/22 at 4:06pm. Refer to telephone interview with the Owner/Administrator on 12/15/22 at 4:20pm. Interview with the medication aide (MA) on 12/15/22 at 4:06pm revealed: -She provided water and other beverages to the residents upon request. -She was not aware water and other beverages were required to be served to residents at each meal. Telephone interview with the Owner/Administrator on 12/15/22 at 4:20pm revealed: -She was not aware it was a requirement for water and other beverages to be served to residents at each meal. -She expected residents to be served water and other beverages at each meal as required.	C 280		
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,	C 330	10A NCAC 13G .1004 Medication Administration The medication aide is the first check on medications	1/02/23

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C 330	Continued From page 4 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, records reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) as evidenced by the administration of an expired medication, including a medication used to treat anxiety, muscle spasms and seizures. The findings are: Resident #2's current FL-2 dated 07/28/22 revealed: -Diagnoses included schizoaffective disorder bipolar type, frequent falls, stroke, hypotension and thrombocytopenia. -There was an order for Diazepam 2mg every six hours as needed for agitation. (Diazepam is a medication used to treat anxiety, muscle spasms, and seizures). Observation of Resident #2's medications on hand on 12/15/22 at 1:30pm revealed: -The order on the bubble pack was for Diazepam 2mg to be administered every six hours as needed for agitation. -The bubble pack contained 32 Diazepam pills. -The expiration date on the label for the medication was 10/04/22. Telephone interview with the facility's contracted pharmacy on 12/15/22 at 3:50pm revealed:	C 330	every month to ensure that medications administered in the facility are administered as prescribed by a licensed prescriber. The Administrator is the second check, to ensure all medications are safe for administration. The MA and the administrator have reviewed this rule failure, and discussed the adherence to monthly monitoring to prevent the administration of expired medications to residents. All the medications in the home have been reviewed and are all within date for safe	

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C 330	Continued From page 5 -Resident #2's Diazepam 2mg was last dispensed on 10/04/21 with an expiration date of 10/04/22. -The facility needed to call the pharmacy when a medication was to be re-filled. Observation of Resident #2 on 12/15/22 at 3:30pm revealed: -The resident was pacing back and forth in the dining/living room area. -The resident was administered Diazepam 2mg. Review of Resident #2's October 2022 medication administration record (MAR) revealed: -There was an entry for Diazepam 2mg, 1 tablet every 6 hours as needed for agitation -There was documentation that Diazepam 2mg, 1 tablet was administered on 10/01/22, 10/02/22, twice on 10/07/22, 10/09/22, twice on 10/10/22, twice on 10/11/22, twice on 10/12/22, 10/13/22, 10/14/22, and 10/31/22. Review of Resident #2's November 2022 MAR revealed: -There was an entry for Diazepam 2mg, 1 tablet every 6 hours as needed for agitation. -There was documentation that Diazepam 2mg, 1 tablet was administered on 11/02/22, 11/22/22, and 11/23/22. Review of Resident #2's December 2022 MAR revealed: -There was an entry for Diazepam 2mg, 1 tablet every 6 tablet hours as needed for agitation. -There was documentation that Diazepam 2mg, 1 tablet was administered on 12/03/22, 12/06/22, and 12/15/22. Interview with the medication aide (MA) on 12/15/22 at 4:06pm revealed:	C 330	administration.	

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C 330	Continued From page 6 -The Owner/Administrator was responsible for contacting the facility's contracted pharmacy to order and/or re-fill medications for residents. -The MA was responsible for notifying the Owner/Administrator when a medication needed to be refilled. -The medication may not be as effective when expired. Telephone interview with the Owner/Administrator on 12/15/22 at 4:20pm revealed: -She was responsible for notifying the facility's contracted pharmacy when a medication needed to be re-filled. -The MA conducted a medication cart audit once a month. -She usually checked behind the MA to ensure the medication cart audit was done once a month. -The expired medication should have been caught. -Expired medication may not be as effective. -She expected medications in the medication cart to be current and not expired. Attempted telephone interview with the mental health provider on 12/15/22 at 3:20pm was unsuccessful.	C 330		
C 353	10A NCAC 13G .1006 (b) Medication Storage 10A NCAC 13G .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record reviews and	C 353	10A NCAC 13G.1006(b) Medication Storage The medications found in the unsecured storage location were for a discharged resident for	1/02/23

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C 353	Continued From page 7 interviews, the facility failed to ensure medications were maintained under locked security for 1 of 2 medication storage carts when not under the direct physical supervision of staff in charge of medication administration. The findings are: Review of the facility's license with an effective date of 01/01/22 and an expiration date of 12/31/22 revealed the facility had a capacity for 6 ambulatory residents. Interview with the medication aide (MA) on 12/15/22 at 8:05am revealed the facility had a census of 5 residents. Observation of a 3-drawer plastic storage contained on 12/15/22 at 1:30pm revealed: -The 3-drawer plastic storage container beside the locked medication cart did not have a locking device and was unable to be secured. -The unsecured 3-drawer plastic storage container contained medications in the top drawer. -The top drawer contained Ingressa 80mg, 19 tablets. (Ingressa is a medication used to treat involuntary body movements). -The top drawer contained Bisacodyl EC 5mg, 29 tablets. (Bisacodyl EC is a medication used to treat constipation). -The top drawer contained a bubble card containing Keppra, 500mg, 12 tablets. (Keppra is a medication use to treat seizures). -The top drawer contained a 2nd bubble card containing Keppra, 500mg, 31 tablets. -The top drawer contained Docusate, 29 capsules. (Docusate is a stool softener used to treat constipation) -The top drawer contained Trihexyphenidyl, 5mg,	C 353	return to the pharmacy. Regardless of this, the medications should have been under lock like until delivery to the pharmacy. medication storage rule has been reviewed with the staff at Pandora FCH. All medications are all serve at the facility. The Administrator is in charge of ensuring all the medications are in a secured medication storage cart.	

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C 353	Continued From page 8 31 tablets. (Trihexyphenidyl is a medication used to treat Parkinson's disease). -The top drawer contained Quetiapine, 300mg, 24 tablets. (Quetiapine is a medication used to treat schizophrenia, bipolar disorder, and depression). -The top drawer contained Hydrochlorothiazide (HCTZ) with 30 tablets. (HCTZ is a medication used to treat high blood pressure and fluid retention). -The top drawer contained Atorvastatin, 20mg, 30 tablets. (Atorvastatin is a medication used to treat high cholesterol and triglyceride levels. It may reduce the risk of angina, stroke, heart attack, and heart and blood vessel problems). -The top drawer contained Diclofenac 2% gel. (Diclofenac is a medication gel used to reduce swelling (inflammation) and pain. -The top drawer contained Muscle Rub cream. (Muscle Rub is a medication cream used to treat minor aches and pains of the muscles and joints. -The top drawer contained artificial tears eye drops. (Artificial Tears is used to treat dry eyes). -The top drawer contained saline nasal spray. (Saline nasal spray is used to help reduce nasal congestion). -The top drawer contained Albuterol Sulfate HFA Inhalant, 90mcg, 181 counts on the dial. (Albuterol Sulfate is a medication used to treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung diseases such as asthma and chronic obstructive pulmonary disease (COPD). Observation of the unsecured medication storage container on 12/15/22 at 11:30am revealed: -Four residents had to pass the unsecured medication storage cart to get to their bedrooms. -Four residents were observed walking by the unsecured medication cart multiple times on	C 353		

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C 353	Continued From page 9 12/15/22 from 8:00am to 4:06pm. -The fifth resident was observed sitting at the kitchen counter about 5 feet from the unlocked 3-drawer plastic medication cart. Interview with the MA on 12/15/22 at 4:06pm revealed: -She placed the overstock or as needed medications received from the pharmacy in the 3-drawer plastic storage container to keep them separate from the medications currently in use. -She was aware that medications should be locked and not accessible to residents for their safety. -She would place the overstock medications in the bottom drawer of the locked and secured medication storage cart. Telephone interview with the Owner/Administrator on 12/15/22 at 4:20pm revealed she expected medications to be locked and secured and not accessible to residents when not under the direct supervision of the MA for the safety of the residents. Attempted telephone interview with the primary care provider (PCP) on 12/15/22 at 3:10pm was unsuccessful.	C 353		