

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL096009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 12/21/2022
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NAME OF PROVIDER OR SUPPLIER GRANTHAM FAMILY CARE # II	STREET ADDRESS, CITY, STATE, ZIP CODE 107 N GEORGIA AVENUE GOLDSBORO, NC 27530
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on December 21, 2022.	C 000		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide documentation that 3 of 3 sampled residents (#1, #2, #3) were tested for tuberculosis disease upon admission in compliance with the control measures adopted by the Commission for Health Services. The finding are: 1. Review of Resident #1's current FL-2 dated 07/15/22 revealed diagnoses included mental retardation, vitamin D deficiency, benign prostatic hypertrophy and thrombocytopenia. Review of Resident #1's Resident Register revealed an admission date of 08/14/92.	C 202		

I don't know what happen to pr why they were out of file but here they are I guess I was over looking them

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

TITLE

(X6) DATE

STATE FORM

Elizabeth Grantam Administrator

OQGP11

1/21/23

If continuation sheet 1 of 7

Reviewed and Acknowledged SCM 04/06/23

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C 202	Continued From page 1 Review of Resident #1's records revealed there was no documentation of Tuberculosis (TB) testing. Refer to interview with the Administrator on 12/21/22 at 11:30am. 2. Review of Resident #2's current FL-2 dated 08/01/22 revealed diagnoses included schizophrenia, diabetes mellitus, type 2, hyperlipidemia, and vitamin D deficiency. Review of Resident #2's Resident Register revealed an admission date of 07/30/12. Review of Resident #2 records revealed: -There was a tuberculosis (TB) test completed on 12/11/12 and read as negative on 12/13/12. -There was no documentation of a second TB test. Refer to interview with the Administrator on 12/21/22 at 11:30am. 3. Review of Resident #3's current FL-2 dated 11/29/21 revealed diagnoses included hypertension, schizophrenia bipolar, and hyperlipidemia. Review of Resident #3's Resident Register dated 08/23/14 revealed: -There was an admission date of 08/23/14. -Resident #3 was admitted to the facility from another facility. Review of Resident #3 records revealed there was no documentation of a tuberculosis (TB) test. Refer to interview with the Administrator on	C 202	Found #1 TB they were here all the time I guess I was over looking making copies of them. Found #2 other (TB) test I just I was to nervous to see them this one for 7/25/12 step 2	12/22/22 12/22/22

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C 202	Continued From page 2 12/21/22 at 11:30am. Interview with the Administrator on 12/21/22 at 11:30am revealed: -She was aware TB tests were required for residents on admission to the facility. -Documentation of TB tests for all three residents were in their records on the last survey in 2021. -She thought documentation of TB test for all 3 residents were in their records.	C 202	Resident #3 have taken his 2 steps doht know what happen to his first set. but I am taking copies of all Residents TB record and file them separte from their books.	1/19/23
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer a medication as ordered for 1 of 3 sampled residents (#2) who did not receive a medication used to treat schizophrenia and bipolar disorder. The findings are: Review of Resident #2's current FL-2 dated 08/01/22 revealed: -Diagnoses included schizophrenia, altered mental status, anemia, and vitamin D deficiency.	C 330		

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C 330	Continued From page 3 -The resident was constantly disoriented. -There was an order for Zyprexa 20mg, 1 tablet at bedtime. (Zyprexa is a medication used for schizophrenia and bipolar disorder). Observation of Resident #2's medications on hand on 12/21/22 at 1:30pm revealed there was no Zyprexa 20mg in the medication cabinet. Review of Resident #2's December 2022 medication administration record (MAR) on 12/21/22 revealed: -There was an entry for Zyprexa 20mg, 1 tablet at bedtime. -There was documentation that Zyprexa 20mg, 1 tablet was administered from 12/01/22 to 12/20/22. Telephone interview with the facility's contracted pharmacy on 12/21/22 at 2:01pm revealed: -Zyprexa 20mg (30 pills) was supposed to be delivered with his other medications and the batch of medications for all residents residing at the facility on 12/01/22. -The Zyprexa 20mg was not included in the batch of medications delivered to the facility on 12/01/22. -The pharmacy was not notified that the Zyprexa 20mg was not included in the batch of medications delivered to the facility on 12/01/22. -The pharmacy would deliver 11 doses of Zyprexa 20mg for Resident #2 to the facility today on 12/21/22 to finish out the month. -Thirty doses of Zyprexa 20mg for Resident #2 would be delivered to the facility a day or two before 01/01/23 with his other medications and the batch of medications for all residents residing at the facility. Interview with the Administrator on 12/22/22 at	C 330		

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C 330	Continued From page 4 2:15pm revealed: -She received the batch of medications delivered to the facility for the December medication administration for all residents. -She did not notice that the Zyprexa 20mg for Resident #2 was not included in the batch of medications because he was prescribed a lot of medications. -She mistakenly signed off Zyprexa 20mg , 1 tablet was administered to Resident #2. Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/21/22 at 2:30pm was unsuccessful.	C 330		
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	C 342		

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C 342	Continued From page 5 administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the medication administration record (MAR) was accurate for 1 of 3 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 08/01/22 revealed: -Diagnoses included schizophrenia, altered mental status, anemia, and vitamin D deficiency. -The resident was constantly disoriented. -There was an order for Zyprexa 20mg, 1 tablet at bedtime. (Zyprexa is a medication used for schizophrenia and bipolar disorder). Observation of Resident #2's medications on hand on 12/21/22 at 1:30pm revealed there was no Zyprexa 20mg in the medication cabinet. Review of Resident #2's December 2022 medication administration record (MAR) on 12/21/22 revealed: -There was an entry for Zyprexa 20mg, 1 tablet at bedtime. -There was documentation that Zyprexa 20mg, 1 tablet was administered from 12/01/22 to 12/20/22. Telephone interview with the facility's contracted pharmacy on 12/21/22 at 2:01pm revealed: -Zyprexa 20mg (30 pills) was supposed to be delivered with his other medications and the batch of medications for all residents residing at the facility on 12/01/22. -The Zyprexa 20mg was not included in the batch of medications delivered to the facility on	C 342	From now on will go by (MAR) when I receive my medications make sure all medication are here will not happen again.	

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C 342	Continued From page 6 12/01/22. -The pharmacy was not notified that the Zyprexa 20mg was not included in the batch of medications delivered to the facility on 12/01/22. -The pharmacy would deliver 11 doses of Zyprexa 20mg for Resident #2 to the facility today on 12/21/22 to finish out the month. -Thirty doses of Zyprexa 20mg for Resident #2 would be delivered to the facility a day or two before 01/01/23 with his other medications and the batch of medications for all residents residing at the facility. Interview with the Administrator on 12/22/22 at 2:15pm revealed she mistakenly signed off on the MAR that Zyprexa 20mg was administered to Resident #2. Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/21/22 at 2:30pm was unsuccessful.	C 342			