STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 survey on 10/03/23.	C 000		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test And Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination (b) Each resident shall have a medical examination prior to admission to the home and annually thereafter. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure residents' FL2s were updated annually for 3 of 3 sampled residents (#1, #2 and #3). The findings are: 1. Review of Resident #1's FL2 dated 09/15/22 revealed diagnoses included bipolar affective disorder, hypertension, and hypothyroidism. Review of Resident #1's record revealed he did not have an updated FL2 completed since 09/15/22. Refer to telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm. Refer to interview with the Administrator on 10/03/23 at 9:24am. 2. Review of Resident #2's current FL-2 dated	C 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

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C 203	Continued From page 1 08/12/22 revealed diagnoses included major depression disorder, gastroesophageal reflux disease (GERD), colon cancer, neurocognitive disorder, and psychosis not otherwise specified. Review of Resident #2's record revealed he did not have an updated FL2 completed since 08/12/22. Refer to telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm. Refer to interview with the Administrator on 10/03/23 at 9:24am. 3. Review of Resident #3's previous FL2 dated 09/29/22 revealed diagnoses included anemia, urinary incontinence, bipolar, and schizoaffective disorder. Review of Resident #3's record revealed she did not have an updated FL2 completed since 09/29/23. Refer to telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm. Refer to interview with the Administrator on 10/03/23 at 9:24am. _____ Telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm revealed: -The residents were last seen by the PCP on 07/25/23. -The PCP did not complete any FL-2s on 07/25/23. -If the facility had brought the FL-2s to the visit on	C 203		

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C 203	Continued From page 2 07/25/23 or if the facility had faxed them within 30 days of the visit the PCP would have completed them. Interview with the Administrator on 10/03/23 at 9:24am revealed: -She was responsible for the residents FL-2's and ensuring they were updated every year. -The residents were seen by the facility's PCP every three months. -The residents were last seen in July 2023 and she did not have the FL-2's signed by the PCP because they were not due yet. -She usually placed reminders for herself on the refrigerator. -She had completely forgotten about the FL-2 and did not realize they were out of date.	C 203		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

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C 231	Continued From page 3	C 231		

referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure 3 of 3 sampled residents (#1, #2 and #3) had a resident assessment completed annually.

The findings are:

1. Review of Resident #1's FL2 dated 09/15/22 revealed diagnoses included bipolar affective disorder, hypertension, and hypothyroidism.

Review of Resident #1's record revealed his care plan was dated 09/15/23; he did not have a care plan dated after 09/15/23

Refer to telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm.

Refer to interview with the Administrator on 10/03/23 at 9:24am.

2. Review of Resident #2's current FL-2 dated 08/12/22 revealed diagnoses included major depression disorder, gastroesophageal reflux disease (GERD), colon cancer, neurocognitive disorder, and psychosis not otherwise specified.

Review of Resident #2's record revealed his care plan was dated 08/12/23; he did not have a care plan dated after 08/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

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C 231	Continued From page 4 Refer to telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm. Refer to interview with the Administrator on 10/03/23 at 9:24am. 3. Review of Resident #3's previous FL2 dated 09/29/22 revealed diagnoses included anemia, urinary incontinence, bipolar, and schizoaffective disorder. Review of Resident #3's record revealed his care plan was dated 09/29/23; he did not have a care plan dated after 09/29/23 Refer to telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm. Refer to interview with the Administrator on 10/03/23 at 9:24am. _____ Telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm revealed: -The residents were last seen by the PCP on 07/25/23. -The PCP did not complete any care plans on 07/25/23. -If the facility had brought the care plans to the visit on 07/25/23 or if the facility had faxed them within 30 days of the visit the PCP would have completed them. Interview with the Administrator on 10/03/23 at 9:24am revealed: -She was responsible for the residents' records and ensuring the care plans were updated every year.	C 231		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

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C 231	Continued From page 5 -The residents were seen by the facility's PCP every three months. -The residents were last seen in July 2023 and she did not have the residents care plans signed by the PCP because they were not due yet. -She usually reminders for herself on the refrigerator. -She had completely forgotten about the dates on the care plans and did not realize they were out of date.	C 231		
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: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 3 residents sampled (#2) who had a referral for a speech therapy evaluation for swallowing problems and a referral for mental health services to receive a monthly injection.. The findings are: Review of Resident #2's FL-2 dated 08/12/22 revealed diagnoses included major depression disorder, gastroesophageal reflux disease (GERD), colon cancer, neurocognitive disorder, and psychosis not otherwise specified. a. Review of a county Emergency Medical Services (EMS) report date 12/15/22 revealed: -EMS were called to the facility on 12/15/22	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

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C 246	Continued From page 6	C 246		

because Resident #2 was choking on a medication tablet and vomited.
-Resident #2 had throat irritation.
-His vitals were taken, and he refused to be transported to the hospital.

Review of Resident #2's physician's after visit report dated 04/05/23 revealed:
-The documented reasons for Resident #2's visit with the physician were a follow-up to colon cancer and coughing while eating.
-There was an order for a referral to a speech therapist (ST) due to choking and swallowing problems.

Review of Resident #2's after visit report from the local Emergency Department (ED) dated 08/02/23 revealed:
-The documented reason for Resident #2's visit was fever and tremors.
-Resident #2 was diagnosed with aspiration pneumonia of the left lung.

Interviews with Resident #2 on 10/03/23 at 8:49am and 1:19pm revealed:
-He did not recall any recent hospital visits.
-He did not recall chocking or vomiting while taking his medications.
-He coughed sometimes but did not know if he coughed while drinking or eating.
-He was missing teeth but did not have dentures or a partial.
-He did not have a special diet order from a physician.
-He had not been seen by a ST.

Telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm revealed:
-Resident #2 was last seen by the PCP in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

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C 246	Continued From page 7 office on 07/25/23. -There was nothing noted about Resident #2 choking or coughing while eating or drinking. -The PCP was not aware of an order from another provider for a referral to a speech therapist due to coughing and choking while eating. -The PCP had not been notified Resident #2 had been seen in the ED for aspiration pneumonia on 08/02/23 nor the choking and vomiting on medication on 12/15/22. -The PCP would like to have been notified of the ED visit on 08/02/23 and about the choking and coughing while eating. -The facility should have notified the PCP about the choking and coughing while eating and drinking because the PCP could have referred Resident #2 to a ST for evaluation. Interviews with the Administrator on 10/03/23 at 10:49am and 3:32pm revealed: -Resident #2 did not have an order for a therapeutic diet. -Resident #2 coughed mostly while drinking. -He drank beverages very quickly and had to be reminded to slow down so he would not cough and choke. -Sometimes he would cough while eating food. -Resident #2 would "cram" large amounts of food into his mouth and eat very quickly. -She would remind him to take smaller bites and to eat slower. -He coughed a couple of times a week when he ate and drank. -The last time he coughed was last week some time and she told him to slow down while eating. -She had not told the PCP about the coughing while eating and drinking but she had told Resident #2's oncologist in April 2023, when he went for a follow-up appointment at the office.	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 246	Continued From page 8	C 246		

-She thought the coughing was related to his GERD.
-She did not call and schedule referral visits for residents; the providers usually called and scheduled the referral appointment for visits.
-The referred provider's office would call her and give her the dates for the appointment.
-She did not call the PCP or the physician about referrals if an appointment had not been scheduled because she had never had that happen before.
-She did not recall anyone calling about an appointment with a ST for Resident #2.
-She did not know what happened to the referral for a speech therapist for Resident #2 and why it was not scheduled.
-She usually put reminders for herself on the refrigerator.
-She did not follow-up on the referral for a ST for Resident #2 with the oncologist or the PCP.
-She did not know why she failed to follow up for the referral order for a ST for Resident #2.

Attempted telephone interview with Resident #2's oncologist on 10/03/23 at 2:48pm was unsuccessful.

b. Review of Resident #2's physician's order dated 02/02/23 revealed an order for haloperidol decanoate (an antipsychotic used to treat mental health conditions) 50mg/mL intermuscular (IM) injection once every four weeks.

Review of Resident #2's record revealed:
-There was documentation Resident #2's mental health provider (MHP) administered his haloperidol decanoate IM injections on 04/25/23, 05/23/23, and 06/20/23.
-There was documentation his primary care provider (PCP) administered his haloperidol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 246	Continued From page 9 decanoate IM injection on 07/25/23. Telephone interview with the pharmacist from the facility's contracted pharmacy on 10/03/23 at 1:28pm revealed: -Resident #2 had a current order for haloperidol decanoate 50mg/mL IM injection administer once every 28 days. -The haloperidol decanoate injection was not on a cycle fill and needed to be requested by the facility for a refill. -One dose of the haloperidol was dispensed on 04/21/23, 05/22/23, 06/19/23 and 07/21/23. -Haloperidol was typically ordered for schizophrenia and behavior issues. -The haloperidol injections were longer acting and usually used in addition to a daily haloperidol tablet to provide more stability to a mental condition. -A possible outcome of not administering the haloperidol injection as ordered would depend on the resident's mental condition, his behavior and if he was ordered a daily haloperidol tablet; an outcome could be issues with increased behaviors. Telephone interview with a representative from Resident #2's PCP's office on 10/03/23 at 1:56pm revealed: -Resident #2 was seen by a MHP who ordered the haloperidol decanoate IM injection. -The Administrator had notified the PCP in July 2023 that Resident #2's MH provider had closed their office. -The PCP agreed to administer Resident #2 his haloperidol decanoate IM injection only one time. -The PCP administered Resident #2 his haloperidol decanoate IM injection in the office on 07/25/23. -The PCP did not provide mental health services	C 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 246	Continued From page 10	C 246		

or administer mental health medication injections.
-The PCP gave the Administrator a referral for an MHP for Resident #2, telephone numbers and names of three MHPs at the 07/25/23 visit.
-The PCP's office tried to reach back out to the Administrator a couple of times to see if an appointment had been made with a MHP for Resident #2 but the Administrator never returned their calls.

Interviews with the Administrator on 10/03/23 at 1:09pm and 3:32pm revealed:
-Resident #2 had been administered his haloperidol decanoate IM injections at the MHP office until it closed in June 2023 without notice.
-She went to the MHP office in July 2023 with Resident #2 and there was only a receptionist who told her the office was closed; there was no one to administer his haloperidol injection and she needed to find another MHP for Resident #2.
-She reached out to Resident #2's PCP who agreed to administer his July 2023 haloperidol injection.
-His PCP only agreed to administer one dose of Resident #2's haloperidol injection out of courtesy but told her she needed to find an MHP for the resident.
-The PCP gave Resident #2 a referral for a MHP and names for MHP in the area.
-There were four residents in the facility who received mental health services and she was trying to find an MHP that would take all four residents, so she only had to make one trip.
-She contacted one MHP in August 2023 who only had two openings, so she did not schedule any appointments with Resident #2 at that provider.
-A second provider would only see one resident.
-She had found a provider who had openings for all four of the residents, but she had to go to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 246	Continued From page 11 office on Friday, 10/06/23 and wait in line because there were only a select number of openings. -Resident #2 had not had his haloperidol decanoate IM injection since 07/25/23 and had missed two doses. -He was usually calm, and his behaviors had remained the same since his last injection in July 2023. Attempted telephone interview with Resident #2's MHP on 10/03/23 at 1:46pm was unsuccessful. _____ The facility failed to ensure to referral and follow up for 1 of 3 residents (#2) with a referral to a speech therapist for coughing and swallowing issues while eating who had an incident of choking and vomiting and had aspiration pneumonia, and continued services from a mental health provider to administer an antipsychotic injection for behaviors. The facility failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 10/03/23. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2023.	C 246		
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	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 330	Continued From page 12	C 330		

by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) related to a monthly injection.

The findings are:

Review of Resident #2's FL-2 dated 08/12/22 revealed:
-Diagnoses included major depression disorder, gastroesophageal reflux disease (GERD), colon cancer, neurocognitive disorder, and psychosis not otherwise specified.
-There was an order for haloperidol decanoate (an antipsychotic used to treat mental health conditions) 50mg/mL intermuscular injection once every four weeks.

Review of Resident #2's August 2023 medication administration record (MAR) revealed:
-There was an entry for haloperidol decanoate 5omg/mL intermuscular injection once every four weeks.
-There was no documentation Resident #2's haloperidol decanoate 50mg/mL was administered during the month of August 2023.

Review of Resident #2's September 2023 MAR revealed:
-There was an entry for haloperidol decanoate 5omg/mL intermuscular injection once every four weeks.
-There was no documentation Resident #2's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 330	Continued From page 13	C 330		

haloperidol decanoate 50mg/mL was administered during the month of August 2023.

Observation of medication on hand for Resident #2 on 10/03/23 at 12:52pm revealed there was no haloperidol decanoate 50mg/mL available for administration.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 10/03/23 at 1:28pm revealed:
-Resident #2 had a current order or haloperidol decanoate 50mg/mL inject intermuscular every 28 days.
-Resident #2's haloperidol decanoate injection was dispensed one injection at a time on 04/21/23, 05/22/23, 06/19/23, and 07/21/23.
-The haloperidol decanoate injection was not on cycle fill; refills had to be requested by the facility.
-The haloperidol decanoate injection had to be administered by a registered nurse (RN), a nurse practitioner (NP) or a physician.
-Haldol decanoate was used to help control behaviors; it was long acting and released over time.
-Outcome from not being administered the injection of haloperidol decanoate as ordered depended on the resident's behaviors and his mental condition.

Telephone interview with a representative from Resident #2's primary care provider's (PCP) office on 10/03/23 at 1:56pm revealed:
-Resident #2 was last seen by the PCP in the office on 07/25/23.
-The PCP administered Resident #2's haloperidol decanoate injection on the visit on 07/25/23.
-The PCP informed the Administrator at the visit on 07/25/23 that they would only do the haloperidol decanoate injection once for Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JUST LIKE HOME FAMILY CARE	617 DURHAM STREET BURLINGTON, NC 27217

(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 330	Continued From page 14 #2 because they were not the mental health provider (MHP) and they did not do mental health injections. -The PCP administered the haloperidol decanoate injection because she was told Resident #2's MHP closed their office. Interviews with Resident #2 on 10/03/23 at 1:19pm revealed: -He had not seen his MHP in a while. -He had not had his haloperidol decanoate injection in a couple of months. -His PCP administered his last injection, but he could not remember when that was. Interviews with the Administrator on 10/03/23 at 1:09pm and 3:32pm revealed: -Resident #2 was administered his haloperidol decanoate IM injections at the MHP office until it closed in June 2023 without notice. -She went to the MHP office in July 2023 with Resident #2 and his injection and there was only a receptionist who told her the office was closed, there was no one to administer his haloperidol injection and she needed to find another MHP for Resident #2. -She reached out to Resident #2's PCP who agreed to administer his July 2023 haloperidol injection. -His PCP only agreed to administer one dose of Resident #2's haloperidol injection out of courtesy but told her she needed to find an MHP for the resident. -Resident #2 had not had his haloperidol decanoate IM injection since 07/25/23 and had missed two doses. -He was usually calm, and his behaviors had remained the same since his last injection in July 2023.	C 330		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001150	A. BUILDING: _____ B. WING _____	10/03/2023

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C 330	Continued From page 15 Attempted telephone interview with Resident #2's MHP on 10/03/23 at 1:46pm was unsuccessful.	C 330		