STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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YOUR LOVING FAMILY CARE HOME I	730 MARIGOLD STREET ROCKY MOUNT, NC 27801

(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 12/29/23.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 4 staff (Staff C and Staff D) who were administering medications had taken and completed the medication clinical skills competency validation checklist, completed medication aide training and the medication aide examination. The findings are: 1. Review of the Staff C, personal care aide (PCA) personnel record revealed: -She was hired on 06/15/16 as a PCA. -There was no documentation that Staff C passed the medication aide written exam. -There was no documentation of the 5-hours, 10-hours or 15-hours medication training. -There was no documentation of a medication clinical skills competency validation checklist. Interview a resident on 12/29/23 at 3:22pm	C 131		

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C 131	Continued From page 1	C 131		

revealed:
-Staff C had administered him medication in the mornings and at night.
-The Administrator did not administer his medication.

Interview with a second resident on 12/29/23 at 3:24pm revealed:
-Staff C administered his medications sometimes in the mornings and at night.
-The Administrator would give him his medication when she worked.
-The PCA checked his blood pressure.

Attempted telephone interview with Staff C on 12/29/23 at 1:01pm was unsuccessful.

Interview with the Administrator on 12/29/23 at 3:39pm revealed:
-Staff C worked as a PCA.
-Staff C had not taken the medication aide examination.
-Staff C had not completed the medication aide training.
-Staff C had administered medication to the residents when she was not at work.
-She had pre-poured the residents medication to be administered by the staff and she would later document on the resident medication administration record (MAR) as administered.

2. Attempted review of Staff D's, cook, personnel record revealed:
-There was not a personnel record on site for Staff D.
-There was no documentation that Staff D passed the medication aide written exam.
-There was no documentation of medication training of 5-hours, 10-hours, or 15-hours.
-There was no documentation of a medication

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C 131	Continued From page 2 clinical skills competency validation checklist. Interview a resident on 12/29/23 at 3:22pm revealed: -Staff D administered him medication in the mornings and at night. -The Administrator would administer his medication sometimes when she worked. Interview with a second resident on 12/29/23 at 3:24pm revealed: -Staff D administered his medications sometimes in the mornings and at night. -The Administrator would give him his medication when she worked. Attempted telephone interview with Staff D on 12/29/23 at 4:02pm was unsuccessful. Interview with the Administrator on 12/29/23 at 3:39pm revealed: -Staff D was hired as the cook for the independent living home. -She was not aware of Staff D administering medication to the residents. -She had pre-poured the residents medication to be administered by Staff C and not Staff D and she would later document on the resident medication administration record (MAR) as administered.	C 131		
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 findings listed on the North Carolina Health Care Personnel Registry according to G.S.	C 145		

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C 145	Continued From page 3 131E-256; This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure the North Carolina Health Care Personnel Registry (HCPR) had no substantiated findings for 2 of 4 facility staff (Staff C, and Staff D) upon hire. The findings are: 1. Review of Staff C's, personal care aide, (PCA) personnel record revealed: -She was hired on 06/15/16 as a PCA. -There was no documentation a HCPR was completed upon hire. Interview a resident on 12/29/23 at 3:22pm revealed Staff C had worked at the home alone with the residents. Interview with a second resident on 12/29/23 at 3:24pm revealed Staff C had worked sometimes at the home administered his medications sometimes in the mornings and at night. Attempted telephone interview with Staff C on 12/29/23 at 1:01pm was unsuccessful. Interview with Administrator on 12/29/23 at 3:39pm revealed: -She had completed a HCPR on Staff C but could not find the HCPR record. -Staff C worked as a PCA and transported residents to various appointments. -Staff C worked alone with the residents. -She was responsible for maintaining personnel records.	C 145		

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C 145	Continued From page 4 2. Attempted review of Staff D's, cook, personnel record revealed: -There was not a personnel record on site for Staff D. -There was no documentation a HCPR was completed upon hire. Interview with a resident on 12/29/23 at 3:22pm revealed Staff D had worked at the home alone with the residents. Interview with a second resident on 12/29/23 at 3:24pm revealed Staff D had worked sometimes at the home and administered his medications sometimes in the mornings and at night. Attempted telephone interview with Staff D on 12/29/23 at 4:02pm was unsuccessful. Interview with Administrator on 12/29/23 at 3:39pm revealed: -Staff D was hired as the cook for the independent living home located next door. -She had not completed a HCPR check for Staff D. -She was responsible for maintaining personnel records.	C 145		
C 176	10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation 10A NCAC 13G .0507 Training on Cardio-Pulmonary Resuscitation Each family care home shall have one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association,	C 176		

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C 176	Continued From page 5 American Red Cross, National Safety Council, American Safety and Health Institute and Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews, observations and interviews, the facility failed to ensure at least one staff person were at all times on the premises who had completed a cardio-pulmonary resuscitation (CPR) and choking management course within the last 24 months for 2 of 4 staff (Staff C and Staff D). The findings are: Observation upon entry to the facility on 12/29/23 at 9:00am revealed: -There was one staff working who identified herself as the supervisor in charge (SIC). -There were 3 residents present in the home. -Two residents were seated in the living room area. -One resident was in his bedroom. Review of Resident #1's record on 12/29/23 at 10:42am revealed Resident #1 did not have a do not resuscitate (DNR) on file. Review of Resident #2's record on 12/29/23 at 11:47am revealed Resident #2 did not have a	C 176		

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C 176	Continued From page 6 DNR on file. Review of Resident #3's record on 12/29/23 at 12:37pm revealed Resident #3 did not have a DNR on file. 1. Review of Staff C's, personal care aide (PCA) personnel record revealed: -She was hired on 06/15/16 as a PCA. -There was no documentation of Staff C completing CPR training. Interview a resident on 12/29/23 at 3:22pm revealed Staff C had worked at the home alone with the residents. Interview with a second resident on 12/29/23 at 3:24pm revealed Staff C had worked alone at the home with the residents. Attempted telephone interview with Staff C on 12/29/23 at 1:01pm was unsuccessful. Interview with Administrator on 12/29/23 at 3:39pm revealed: -Staff C worked as a PCA and she worked alone with the residents when scheduled. -Staff C also transported residents to appointments. -Staff C had completed the CPR training. -She did not remember when the CPR training was completed. -She was responsible for maintaining personnel records. 2. Attempted review of Staff D's, cook, personnel record revealed: -There was not a personnel record on site for Staff D. -There was no documentation of Staff D	C 176		

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C 176	Continued From page 7 completing CPR training. Interview a resident on 12/29/23 at 3:22pm revealed Staff D had worked sometime alone at the home alone with the residents in mornings. Interview with a second resident on 12/29/23 at 3:24pm revealed Staff D had sometimes worked alone at the home with the residents. Interview with Administrator on 12/29/23 at 3:39pm revealed: -Staff D was hired as the cook for the independent living home located next door. -Staff D had not completed CPR training. -Staff D did not work at the facility. -She was responsible for maintaining personnel records. _____ The Administrator failed to ensure at least one staff in the facility at all times had successfully completed Cardio-Pulmonary Resuscitation within the last 24 months which placed the residents who were full codes at risk for the possible delay of life-saving measures if needed. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/29/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 12, 2024.	C 176		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care	C 249		

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C 249	Continued From page 8 (c) The facility shall assure documentation of the following in the resident's record: (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 record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (#3) with orders for blood pressure (BP) checks bi-weekly. The findings are: Review of Resident #3's current FL2 dated 06/09/23 revealed: -Diagnoses included dementia without behaviors, coronary artery disease, hypertension with heart failure, moderate persistent asthma without complication, major depression (remission) and neuropathy. -BP checks were to be obtained bi-weekly. Review of Resident #3's vital sign October 2023 log revealed: -There was one BP check completed and the reading was 146/82. -There were no other BP readings documented. -The October 2023 vital sign log was not dated. Review of Resident #3's vital sign November 2023 log revealed: -There was one BP check completed and the reading was 134/76. -There were no other BP readings documented.	C 249		

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C 249	Continued From page 9 -The November 2023 vital sign log was not dated. Review of Resident #3's vital sign December 2023 log revealed: -There was one BP check completed and the reading was 140/68. -There were no other BP readings documented. -The December 2023 vital sign log was not dated. Interview with Resident #3 on 12/29/23 at 10:06am revealed: -He did have high blood pressure. -Staff checked his blood pressure daily. -His blood pressure had not been high. Interview with the Assistant Administrator on 12/29/23 at 2:01am revealed: -Her title was not the supervisor in charge (SIC) but the Assistant Administrator. -She worked Monday through Friday from 8:00am to 5:00pm. -She had not completed BP checks for Resident #3. Interview with the Administrator on 12/29/23 at 1:29pm revealed: -She had not notified the PCP to verify the order to check Resident #3's BP bi-weekly. -Resident #3's BP was checked once monthly because the other orders for BP checks were once monthly for the other residents. -Resident #3 had not complained of having any symptoms of high BP. Attempted telephone interview with Resident #3's primary care provider (PCP) on 12/29/23 at 2:27pm was unsuccessful.	C 249		

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C 288	Continued From page 10	C 288		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on record interviews, reviews and observations the facility failed to ensure residents were offered activities designed to promote the residents' active involvement. The findings are: Observation of the facility on 12/29/23 from 9:00am to 4:24pm revealed: -No activities were offered to the residents. -There was not an activities calendar posted in the facility. -Three residents were sitting in the living room watching TV. -Staff had not facilitated activities. Interview with a resident on 12/29/23 at 10:06am revealed: -Activities were offered about 2 or 3 times a week but not every day. -Sometimes they played checkers. -The residents would go shopping and out to eat on Fridays. Interview with a second a resident on 12/29/23 at 3:22pm revealed the residents only went shopping or out to eat on Fridays. Interview with the Assistant Administrator on 12/29/23 at 2:01pm revealed: -Residents went on outings each Friday.	C 288		

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C 288	Continued From page 11 -Sometimes she had the residents to play board and cards games. Interview with the Administrator on 12/29/23 at 1:59pm revealed: -The activities calendar was posted in the kitchen. -She did not know who had removed the activities calendar. -The activities supplies were kept next door at the independent living house.	C 288		
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 record reviews and interviews, the facility failed to ensure the documentation on the medication administration records (MARs) included the initials of the medication aide (MA) who administered scheduled and as needed (PRN) medication for 3 of 3 residents sampled. The findings are: 1. Review of Resident #1's current FL-2 dated	C 341		

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C 341	Continued From page 12 10/24/23 revealed diagnoses included asthma, schizophrenia and leukocytopenia. Review of Resident #1's medication administration record (MAR) for October 2023 revealed: -There were handwritten entries for 5 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 2 oral as needed (PRN) medications. -There was documentation 5 oral medications where the Administrator signed off on administering medications at 8:00am and 8:00pm on 10/01/23 to 10/31/23. -There was documentation 2 oral PRN medications where the Administrator signed off on administering medications on 10/01/23 to 10/31/23. Review of Resident #1's MAR for November 2023 revealed: -There were handwritten entries for 5 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 2 oral PRN medications. -There was documentation that 5 oral medications where the Administrator signed off on administering medications at 8:00am and 8:00pm on 11/01/23 to 11/30/23. -There was documentation that 2 oral PRN medications where the Administrator signed off on administering medications11/01/23 to 11/30/23. Review of Resident #1's MAR for December 2023 revealed: -There were handwritten entries for 5 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 2 oral PRN medications.	C 341		

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C 341	Continued From page 13 -There was documentation that 5 oral medications where the Administrator signed off on administering medications at 8:00am and 8:00pm on 12/01/23 to 12/28/23. -There was documentation that 5 oral medications where the Administrator signed off on administering medicationsat 8:00am on 12/29/23. -There was documentation that 2 oral PRN medication where the Administrator signed off on administering medications on 12/01/23 to 12/28/23. -There was documentation that 2 oral PRN medication where the Administrator signed off on administering medications 12/29/23. Interview with Resident #1 on 12/29/23 at 3:24pm revealed: -The PCA and cook had administered medication sometimes in the morning and at night. -The cook and PCA worked alone with the residents. -The Administrator at times would administer his medication. Attempted telephone interview with personal care aide (PCA) on 12/29/23 at 1:01pm was unsuccessful. Attempted telephone interview with the cook on 12/29/23 at 4:02pm was unsuccessful. Refer to interview with the Assisant Administrator on 12/29/23 at 2:01pm. Refer to interview with the Administrator on 12/29/23 at 3:39pm. 2. Review of Resident #2's current FL-2 dated 10/17/23 revealed diagnoses included mental	C 341		

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C 341	Continued From page 14 retardation, dementia, loss of vision in eye, speech disorder and unspecified mental disorder. Review of Resident #2's medication administration record (MAR) for October 2023 revealed: -There were handwritten entries for 7 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 1 oral as needed (PRN) medication. -There was documentation that 7 oral medications where the Administrator signed off on administering medications at 8:00am and 8:00pm on 10/01/23 to 10/31/23. -There was documentation that 1 oral medication where the Administrator signed off on administering medications at 8:00am and 8:00pm on 10/01/23 to 10/31/23. -There was documentation that 1 oral PRN medication where the Administrator signed off on administering medications on 10/01/23 to 10/31/23. Review of Resident #2's MAR for November 2023 revealed: -There were handwritten entries for 7 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 1 oral PRN medication. -There was documentation that 7 oral medications where the Administrator signed off on administering medications at 8:00am and 8:00pm on 11/01/23 to 11/30/23. -There was documentation that 1 oral PRN medication where the Administrator signed off on administering medications at 8:00am on 11/01/23 to 11/30/23. Review of Resident #2's MAR for December 2023 revealed:	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL033006	A. BUILDING: _____ B. WING _____	12/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YOUR LOVING FAMILY CARE HOME I	730 MARIGOLD STREET ROCKY MOUNT, NC 27801

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C 341	Continued From page 15 -There were handwritten entries for 1 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 2 oral PRN medication. -There was documentation that 7 oral medications where the Administrator signed off on administering medicationsat 8:00am and 8:00pm on 12/01/23 to 12/28/23. -There was documentation that 7 oral medication where the Administrator signed off on administering medications at 8:00am on 12/29/23. -There was documentation that 1 oral PRN medication where the Administrator signed off on administering medications8:00am and 8:00pm on 12/01/23 to 12/28/23. -There was documentation that 1 oral PRN medication where the Administrator signed off on administering medications at 8:00am on 12/29/23. Based on observations, record reviews and interviews Resident #2 it was deteremined Resident #2 was not able to be interviewed. Attempted telephone interview with personal care aide (PCA) on 12/29/23 at 1:01pm was unsuccessful. Attempted telephone interview with the cook on 12/29/23 at 4:02pm was unsuccessful. Refer to interview with the Assistant Administrator on 12/29/23 at 2:01pm. Refer to the interview with the Administrator on 12/29/23 at 3:39pm. 3. Review of Resident #3's current FL2 dated 06/09/23 revealed diagnoses included dementia	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 341	Continued From page 16 without behaviors, coronary artery disease, hypertension with heart failure, moderate persistent asthma without complication, major depression (remission) and neuropathy. Review of Resident #3's medication administration record (MAR) for October 2023 revealed: -There were handwritten entries for 12 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 1 oral medication scheduled for 4:00pm. -There were handwritten entries for 3 oral as needed (PRN) medications. -There was documentation that 12 oral medications where the Administrator signed off on administering medicationsat 8:00am and 8:00pm on 10/01/23 and 10/31/23. -There was documentation that 1 oral medication where the Administrator signed off on administering medications at 4:00pm on 10/01/23 to 10/31/23. Review of Resident #3's MAR for November 2023 revealed: -There were handwritten entries for 12 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 1 oral medication scheduled for 4:00pm. -There were handwritten entries for 3 oral PRN medications. -There was documentation that 12 oral medications where the Administrator signed off on administering medications at 8:00am and 8:00pm on 11/01/23 and 11/30/23. -There was documentation that 3 oral medications where the Administrator signed off on administering medications at 4:00pm on 11/01/23 to 11/30/23.	C 341		

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C 341	Continued From page 17 Review of Resident #3's MAR for December 2023 revealed: -There were handwritten entries for 12 oral medications scheduled for 8:00am and 8:00pm. -There were handwritten entries for 1 oral medication scheduled for 4:00pm. -There were handwritten entries for 3 oral PRN medications. -There was documentation that 12 oral medications where the Administrator signed off on administering medications at 8:00am and 8:00pm on 12 and 12/01/23 to 12/28/23. -There was documentation that 3 oral medication where the Administrator signed off on administering medications at 4:00pm on 12/01/23 to 12/28/23. -There was documentation that 12 oral medication where the Administrator signed off on administering medications at 8:00am on 12/29/23. -There was documentation that 3 oral PRN medication where the Administrator signed off on administering medications at 8:00am and 8:00pm on 12/01/23 to 12/28/23. Interview with Resident #3 on 12/29/23 at 3:22pm revealed: -The cook and PCA had administered his medication. -The cook and PCA administered the medication in the mornings and evenings. -The cook and PCA had worked alone with the residents. -The Administrator at times would administer his medication. Attempted telephone interview with personal care aide (PCA) on 12/29/23 at 1:01pm was unsuccessful.	C 341		

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C 341	Continued From page 18 Attempted telephone interview with the cook on 12/29/23 at 4:02pm was unsuccessful. Refer to interview with the Assisant Administrator on 12/29/23 at 2:01pm. Refer to the interview with the Administrator on 12/29/23 at 3:39pm. _____ Interview with the Assistant Administrator on 12/29/23 at 2:01pm revealed: -She did not administer medications to residents. -She had not completed the medication aide exam. -She administered the morning medication on 12/29/23. Interview with the Administrator on 12/29/23 at 3:39pm -The PCA and cook had not taken the medication aide examination. -The PCA and cook had not completed the medication aide training. -The PCA had administered medication to the residents when she was not at work. -The cook worked next door at the independent living home. -She had pre-poured the residents medication to be administered by the PCA and she would later document on the resident MAR as administered. -She thought because the medications were prepoured the staff could administer the medications to the residents. -She was not aware of the cook administering medication to the residents.	C 341		

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C 375	Continued From page 19	C 375		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a licensed pharmacist,	C 375		

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C 375	Continued From page 20	C 375		

provider or registered nurse completed a quarterly onsite review for 3 of 3 sampled residents (#1, #2 and #3) which included the reconciliation of current orders, medication administration records (MARs) and medications in the facility.

The findings are:

1. Review of Resident #1's current FL-2 dated 10/24/23 revealed diagnoses included asthma, schizophrenia and leukocytopenia.

Review of Resident #1's quarterly medication review revealed:
-There was a medication review on 06/24/23.
-There was not another medication review completed since 06/24/23.

Refer to interview with the facility's local pharmacy Nurse on 12/29/23 at 2:27pm.

Refer to telephone interview with the Administrator on 12/29/23 at 11:43am.

2. Review of Resident #2's current FL-2 dated 10/17/23 revealed diagnoses included mental retardation, dementia, loss of vision in eye, speech disorder and unspecified mental disorder.

Review of Resident #2's quarterly medication review revealed there was no documentation of a completed quarterly review.

Refer to interview with the facility's local pharmacy Nurse on 12/29/23 at 2:27pm.

Refer to telephone interview with the Administrator on 12/29/23 at 11:43am.

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C 375	Continued From page 21 3. Review of Resident #3's current FL2 dated 06/09/23 revealed diagnoses included dementia without behaviors, coronary artery disease, hypertension with heart failure, moderate persistent asthma without complication, major depression (remission) and neuropathy. Review of Resident #3's quarterly medication review revealed there was no documentation of a completed quarterly review. Refer to telephone interview with the facility's local pharmacy Nurse Supervisor on 12/29/23 at 2:27pm. Refer to telephone interview with the Administrator on 12/29/23 at 11:43am. _____ Telephone interview with the facility's local pharmacy Nurse Supervisor on 12/29/23 at 2:27pm revealed: -The pharmacy reviews were completed in September 2023 for Resident #1, Resident #2 and Resident #3 by the LHPS Nurse. -There were issues with the facility keeping their residents' records in order. -The LHPS Nurse tried to schedule an appointment in December 2023 to complete the pharmacy reviews, but the Administrator would not accommodate the LHPS Nurse coming to the facility on the weekend. -The LHPS Nurse was only available on the weekend during the month of December 2023. -Interview with the Administrator on 12/29/23 at 11:43am revealed she was not familiar with the pharmacy reviews.	C 375		