STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL032142	A. BUILDING: _____ B. WING _____	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUPREME FAMILY CARE HOME	1120 BENNING STREET DURHAM, NC 27703

(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 with an exit date of March 8, 2024.	C 000		
C 264	10A NCAC 13G .0904(c)(1) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (1) Menus shall be prepared at least one week in advance with serving quantities specified and in accordance with the daily food requirements in Paragraph (d) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to prepare menus at least one week in advance with serving quantities specified and in accordance with the daily food requirements. The findings are: Observation of the kitchen on 03/08/24 at 7:45am revealed: -There was a weekly menu posted on the refrigerator from 03/03/24 to 03/09/24. -There were hand-written entries for breakfast, lunch, and dinner for each day of the week, Sunday through Saturday. -The hand-written entry consisted of two or three foods for each meal. -There was no serving size listed on the menu. -There were no liquids to be served on the weekly menu.	C 264		

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C 264	Continued From page 1 -The menu was not signed by a Registered Dietician (RD). Observation of the breakfast service meal on 03/08/24 at 7:48am revealed the residents were served waffles, applesauce, and a cup of water. Interview with 2 residents on 03/08/24 between 7:50am and 8:00am revealed the residents were served waffles, applesauce, and a cup of water. Interview with the medication aide (MA) on 03/08/24 at 7:45am and 11:21am revealed: -He prepared breakfast, lunch, and dinner for the residents. -He prepared what was listed on the menu. -This morning, 03/08/24, he served waffles, applesauce, and water to the residents. -He did not serve anything other than what was on the menu. -He did not know he should have served bacon or sausage with the waffles this morning; it was not on the menu to be served. -He did not know the residents were to receive juice or citrus fruit daily. -He did not know the residents were to be served milk or a milk product three times daily. -He did not know the residents were to be served eggs at least three times weekly. -He did not know residents were required to have a specific amount or serving of each food or liquid. Telephone interview with the Director on 03/08/24 at 11:12am revealed: -The facility purchased cycle menus for each season from a RD years ago. -She did not leave the menus in the facility because they would get destroyed by the Residents and the staff.	C 264		

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C 264	Continued From page 2 -She hand-wrote a menu each week and placed it in the kitchen on the refrigerator. -She wrote the main foods for the meal but left it open for the staff to serve what the residents wanted. Interview with the Administrator on 03/08/24 at 11:00am and 11:30am revealed: -The Director prepared the menu for the facility. -The Director prepared the menu based on the food that was available in the home. -The facility had signed menus from a RD that were kept in a book with the Director. -The Director would shop for food based on the menu. -She was aware the Director wrote the menus out by hand because there was a problem keeping the signed menus in the facility. -The hand-written menu needed to be a complete menu to include all food groups and servings of each food/liquid. -The menu on the refrigerator for the week of 03/03/24 to 03/09/24 was an incomplete menu. -She did not know the menus were incomplete. -She expected the menus to be complete and the residents served three balance meals a day.	C 264		
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.	C 330		

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C 330	Continued From page 3	C 330		

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 for 1 of 3 sampled residents (#1) related to treat anxiety and depression.

The findings are:

Review of Resident #1's current FL-2 dated 11/21/23 revealed diagnoses included schizophrenia disorder bipolar type and autism spectrum disorder.

There was a signed physician's order dated 12/01/23 for mirtazapine 15mg (used to treat anxiety and depression) at bedtime.

There was a signed physician's order dated 03/04/24 to increase mirtazapine to 30mg at bedtime.

Review of Resident #1's March 2024 electronic medication administration record (eMAR) from 03/04/24 to 03/07/24 revealed:
-There was an entry for mirtazapine 15mg at bedtime with a discontinued date of 03/04/24.
-There was an entry for mirtazapine 30mg at bedtime with a scheduled administration time of 8:00pm.
-There was documentation mirtazapine 30mg was administered at 8:00pm from 03/05/24 to 03/07/24.

Observation of Resident #1's medications on hand on 03/08/24 at 10:30am revealed:
-There was a bubble pack of mirtazapine 15mg available for administration with a dispensed date

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C 330	Continued From page 4 of 02/16/24. -The pharmacy dispensed 29 mirtazapine 15mg. -There were 10 of 29 mirtazapine remaining. -There was no mirtazapine 30mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 03/08/24 at 10:45am revealed: -The pharmacy had an order for mirtazapine 30mg at bedtime dated 03/04/24 for Resident #1. -The pharmacy dispensed 11 mirtazapine 30mg on 03/04/24 and delivered the medication to the facility the same evening. -Mirtazapine was used for mood and sleep. Observation of the Administrator on 03/08/24 at 10:48am revealed the Administrator unlocked the locked box on the front porch and removed three bags of medication; one bag contained 11 mirtazapine 30mg for Resident #1. Telephone interview with the medication aide (MA) on 03/08/24 at 10:40am revealed: -He administered Resident #1 mirtazapine 15mg. -He did not know Resident #1's mirtazapine had been changed to 30mg at bedtime. -The Primary Care Provider (PCP) faxed the prescription to the pharmacy. -He did not know the PCP had faxed a new prescription to the pharmacy. -He did not notice the new entry on the eMAR for mirtazapine 30mg at bedtime. Interview with the Administrator on 03/08/24 at 10:42pm revealed: -The PCP faxed all prescriptions to the pharmacy. -The pharmacy enters the new medication order into the eMAR. -The pharmacy sends the new medication out the	C 330		

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C 330	Continued From page 5 same night as they receive the new order. -The delivery of the medication would be placed inside the locked box on the front porch. -The MA would retrieve the medication from the locked box the following morning. -The MA did not know there was a new medication ordered, so he did not know to look in the locked box of the front porch. -The MA did not check the locked box daily; the MA checked the locked box monthly when the cycled medications were due to be delivered and if he was aware of a new medication being delivered. Resident #1 was unavailable for an interview. Attempted telephone interview with the PCP on 03/08/24 at 11:00am was unsuccessful.	C 330		