STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013047	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBURBAN GUARDIANSHIP	1061 UNION STREET SOUTH CONCORD, NC 28025

(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 a annual survey on 03/26/24.	C 000		
C 320	10A NCAC 13G .1002 (f) Medication Orders 10A NCAC 13G .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 2 of 3 sampled residents (Residents #2 and #3). The findings are: 1. Review of Resident #3's current FL2 dated 05/23/23 revealed: -Diagnoses included schizophrenia, encephalopathy and hyporammonemia -There was an order for trazodone 50mg one tablet at bedtime (used to treat insomnia), invega sustenna 156 mg inject intramuscularly in left deltoid every 28 days (used to treat schizophrenia), Robitussin 10-100mg - give 10cc by mouth every 6 hours as needed (used to treat cough and congestion), tylenol 325mg, give 2 tablets by mouth every 4 hours as needed (used to treat for a fever up to 101 farenheit), milk of magnesia 1200 mg/15ml suspension, take 30ml by mouth daily as needed (used to treat	C 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013047	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBURBAN GUARDIANSHIP	1061 UNION STREET SOUTH CONCORD, NC 28025

(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 320	Continued From page 1	C 320		

constipation), mylanta maximum strength 400-400-40 mg/5ml liquid, give 10ml by mouth as needed up to 6 times a day in 24 hours (used to treat heartburn or indigestion).

Review of Resident #3's record revealed his Primary Care Provider (PCP) had not completed a six-month review of medications.

Refer to the interview with the Owner on 03/26/24 at 12:50pm.

Refer to the interview with the Administrator on 03/26/24 at 10:50am.

2. Review of Resident #2's current FL2 dated 08/21/23 revealed:
-Diagnoses included schizophrenia, hypertension, hypothyroidism, and peripheral vascular disease.
-There was an order for acetaminophen 500mg every 6 hours as needed for pain, amlodipine besalyte (a medication used to treat high blood pressure) 2.5mg every day, aspirin (a medication used to thin the blood) 81mg every day, vitamin D3 (a medication used to strengthen bones) 1000mcg 2 times a day, diphenhydramine HCL (a medication used to treat allergies) 25mg at bedtime as needed for sleep, divalproex sodium (a medication used to stabilize moods) 500mg, (3) at bedtime, haloperidol (a medication used auditory hallucinations) 10mg at bedtime, levothyroxine sodium (a medication used to treat a thyroid deficiency) 25mcg on an empty stomach every day, metoprolol tartrate (a medication used to treat high blood pressure and high heart rate) 25mg, (1/2) 2 times a day, multivitamin (a medication used to treat a vitamin deficiency)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013047	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBURBAN GUARDIANSHIP	1061 UNION STREET SOUTH CONCORD, NC 28025

(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 320	Continued From page 2 every day, olanzapine (a medication used to treat psychotic disorders) 20mg at bedtime, pravastatin sodium (a medication used to treat cardiovascular disorders) 40mg at bedtime, and trazodone HCL (a medication used to treat depression) 100mg, (2) at bedtime. Review of Resident #2's record revealed his Primary Care Physician (PCP) had not completed a six-month review of medications. Refer to the interview with the Owner on 03/26/24 at 12:50pm. Refer to the interview with the Administrator on 03/26/24 at 10:50am. _____ Interview with the Owner on 03/26/24 at 12:50pm revealed: -The Administrator was responsible for obtaining all signed physician's orders every 6 months. -He was not aware the signed physician's orders were not obtained from the PCP every 6 months. Interview with the Administrator on 03/26/24 at 10:50am revealed: -All the residents in the facility were Veterans. -The policy was for her to check all Electronic Medical Records (EMR) for each resident after they returned from the Veteran's Administration Hospital (VA). -She was responsible for logging into the VA EMR for each resident and printing off all new orders. -She was responsible for comparing all resident orders from their EMR to the upcoming month's electronic Medication Record (eMAR) to make sure all the orders were correct and current. -She did not know she was to have the primary care physician (PCP) sign physician's orders	C 320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013047	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBURBAN GUARDIANSHIP	1061 UNION STREET SOUTH CONCORD, NC 28025

(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 320	Continued From page 3 every 6 months to ensure all the medication and or treatments were current.	C 320		
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;	C 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013047	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBURBAN GUARDIANSHIP	1061 UNION STREET SOUTH CONCORD, NC 28025

(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 375	Continued From page 4 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure pharmacy reviews were completed quarterly for 2 of 3 residents sampled (#2 and #3). The findings are: 1. Review of Resident #3's current FL2 dated 05/23/23 revealed diagnoses included schizophrenia, encephalopathy and hyperammonemia. Review of Resident #3's Resident Register revealed an admission date of 09/12/18. Review of Resident #3's record on 03/26/24 revealed: -The last quarterly pharmacy review was completed on 06/09/22. -There was no documentation of a current quarterly pharmacy review. Refer to the interview with the Owner on 03/26/24 at 12:50pm. Refer to the interview with the Administrator on 03/26/24 at 10:50am. 2. Review of Resident #2's current FL2 dated 08/21/23 revealed: -Diagnoses included schizophrenia, hypertension, hypothyroidism, and peripheral vascular disease. Review of Resident #2's Resident Register revealed an admission date of 05/02/11.	C 375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL013047	A. BUILDING: _____ B. WING _____	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUBURBAN GUARDIANSHIP	1061 UNION STREET SOUTH CONCORD, NC 28025

(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 375	Continued From page 5 Review of Resident #2's record on 03/26/24 revealed: -The last quarterly pharmacy review was completed on 06/09/22. -There was no documentation of a current quarterly pharmacy review. Refer to the interview with the Owner on 03/26/24 at 12:50pm. Refer to the interview with the Administrator on 03/26/24 at 10:50am. _____ Interview with the Owner on 03/26/24 at 12:50pm revealed: -The Administrator was responsible for contacting the pharmacy quarterly when the pharmacy reviews were due. -He was not aware the pharmacy reviews were not completed quarterly. Interview with the Administrator on 03/26/24 at 10:50am revealed: -The contracted pharmacy was responsible for repackaging all resident's VA medications for administration. -She was not aware the contracted pharmacy was not completing the required pharmacy review every quarter. -There were not any issues or concerns with the resident's medications so she was never aware the pharmacy reviews were not completed.	C 375		