STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL092232	A. BUILDING: _____ B. WING _____	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANN'S NEW DAY	400 PARNELL STREET RALEIGH, NC 27610

(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 completed an annual survey on 05/02/24.	C 000		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to improper storage of food items in the refrigerator. The findings are: Observation of the kitchen refrigerator on 05/02/24 at 9:00am revealed: -There was a styrofome container containing cooked ribs without date opened labels. -There was a styrofome container containing cooked rice and vegetables without date opened labels.	C 257		

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C 257	Continued From page 1 -There were three cooked chicken thighs wrapped in tin foil without date cooked labels. -There was a plastic bag containing two uncooked patties without date opened labels. -There was a pot with a plastic bag inside containing uncooked chicken without date opened labels. -There was a tupperware containing potatoes without a date cooked label. Observation of the freezer on 05/02/24 at 9:15am revealed two tupperware containers containing food without labels. Interview with the Supervisor in charge (SIC) on 05/02/24 at 11:45am revealed: -She understood that all food placed in the refrigerator should be labeled. -All staff members were responsible for making sure that the food in the refrigerator. -She expected all staff to label opened food before placing it in the refrigerator. Telephone interview with the Administrator on 05/02/24 at 12:50pm revealed: -She was aware that all opened or cooked foods need to be labeled. -Sometimes when residents got takeout food they didn't label it before placing it in the refrigerator. -She expected all staff to label opened food before placing it in the refrigerator.	C 257		
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	C 375		

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C 375	Continued From page 2	C 375		

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, provider or registered nurse completed a quarterly on-site medication review for 3 of 3 sampled residents (#1, #2, #3).

The findings are:

1. Review of Resident #1's current FL-2 dated

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C 375	Continued From page 3 04/17/24 revealed diagnoses included schizoaffective disorder, intellectual disability, and type 2 diabetes mellitus. Review of Resident #1's record revealed the most recent medication reviews were completed on 12/06/23 and 08/29/23. Attempted telephone interview on 05/02/24 at 12:30pm with Resident #1's pharmacist was unsuccessful. Refer to interview with the SIC on 05/02/24 at 11:15am. Refer to interview with the Administrator on 05/02/24 at 12:45pm. 2. Review of Resident #2's current FL-2 dated 01/01/24 revealed diagnoses included bi-polar disorder, schizophrenia, and hypertension. Review of Resident #2's record revealed the most recent medication reviews were completed on 12/06/23 and 08/29/23. Attempted telephone interview on 05/02/24 at 12:30pm with Resident #2's pharmacist was unsuccessful. Refer to interview with the SIC on 05/02/24 at 11:15am. Refer to interview with the Administrator on 05/02/24 at 12:45pm. 3. Review of Resident #3's current FL-2 dated 04/17/24 revealed diagnoses included bi-polar 2 with psychosis, type 2 diabetes, and anxiety.	C 375		

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C 375	Continued From page 4 Review of Resident #3's record revealed the most recent medication reviews were completed on 12/06/23 and 08/29/23. Attempted telephone interview on 05/02/24 at 12:30pm with Resident #3's pharmacist was unsuccessful. Refer to interview with the SIC on 05/02/24 at 11:15am. Refer to interview with the Administrator on 05/02/24 at 12:45pm. _____ Interview with the SIC on 05/02/24 at 11:15am revealed: -She was aware the pharmacy reviews were supposed to be completed quarterly for each resident. -The quarterly pharmacy reviews were overdue and should have been completed in March. -It was the responsibility of the Administrator and herself to ensure all paperwork for the residents was up to date. Interview with the Administrator on 05/02/24 at 12:45pm revealed: -She was aware the pharmacy reviews were supposed to be completed quarterly for each resident. -She believed the pharmacy reviews may have been completed in March 2024. -The facility Licensed Practical Nurse (LNP) was responsible for auditing the resident records monhtly to ensure all paperwork was up to date. Attempted telephone interview with the facility LPN on 05/02/24 at 1:00pm was unsuccessful.	C 375		