STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL073011	A. BUILDING: _____ B. WING _____	08/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN YEARS FAMILY CARE HOME	410 MONTFORD DRIVE ROXBORO, NC 27573

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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on August 13, 2024.	C 000		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 5 sampled residents (#4) who had a diagnosis of dementia and required verbal prompting to exit the facility during a fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Observation of the facility on 08/13/24 at 8:00am revealed 5 residents resided in the facility. Review of the facility's undated fire alarm	C 022		

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C 022	Continued From page 1	C 022		

procedure revealed:
-The residents were to evacuate the facility when the smoke alarm sounded.
-The staff should attempt to put out the fire with the fire extinguisher if possible.
-If the staff was unable to put the fire out with the fire extinguisher, the staff would call 911.
-The residents were to relocate to a safe area away from the building.

Review of the facility's fire drill dated June 2024 revealed:
-The Administrator conducted the fire drill.
-The number of people evacuated was 5.
-Time required to evacuate was 2 to 3 minutes.

Review of the facility's fire drill dated July 2024 revealed:
-The Administrator conducted the fire drill.
-The number of people evacuated was 5.
-Time required to evacuated was 2 to 3 minutes.

Review of Resident #4's current FL-2 dated 01/15/24 revealed:
-Diagnoses included dementia and hyperlipidemia.
-He was intermittently disoriented most of the time.
-He was ambulatory but did not walk well.
-He had functional limitations with his speech.
-He was mostly non-verbal for communication of needs.

Review of Resident #4's Resident Register revealed:
-There was an admission date of 11/29/22.
-He required assistance with correspondence and orientation to time and place.
-He had significant memory loss and must be directed.

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C 022	Continued From page 2 Review of Resident #4's assessment and care plan dated 03/6/24 revealed: -He did not really talk; when he did, it was weak. -He had to be totally directed. -He had dementia. -He had no problem ambulating. -He was always disoriented. -He was forgetful and needed reminders. -He had significant memory loss. -His speech and communication needs were weak. -He required supervision with ambulation and transferring. -He required extensive assistance with dressing. -He was totally dependent with toileting, bathing, and grooming. -The care plan was signed by Resident #4's Primary Care Provider (PCP) on 03/18/24. Interview with Resident #4 on 08/13/24 at 8:20am revealed Resident #4 would not speak to the surveyor. Observation of the facility on 08/13/24 at various times between 8:15am and 2:00pm revealed: -Resident #4 ambulated to the dining room table for meals. -Resident #4 would walk out the sliding doors to the back porch after meals for 10 minutes before returning to his room. -Resident #4 was lying on his bed in his bedroom. -Resident #4 did not speak to anyone. Observation of the facility on 08/13/24 between 10:50am and 10:55am revealed: -At 10:50am, Resident #4 was in his room lying on his bed. -At 10:51am, the Supervisor-in-Charge (SIC) activated the fire alarm.	C 022		

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C 022	Continued From page 3 -There was a loud audible alarm that could be heard throughout the facility. -At 10:53am, Resident #4 remained in his bed. -At 10:53am, the SIC approached Resident #4 lying in his bed and instructed him to get out of bed because there was a fire drill. -Resident #4 sat up on side of the bed, put his shoes on, and exited the front door of the facility with instructions from the SIC. Interview with the SIC on 08/13/24 at 11:00am revealed: -Resident #4 did not react to the fire alarm when it sounded. -He had dementia and needed instructions from the staff. -He went to Resident #4's bedside and asked him if he heard the fire alarm. -Resident #4 was instructed to get up and go outside. Interview with a second SIC on 08/13/24 at 1:05pm revealed: -Resident #4 had to be instructed by the staff to leave the facility during monthly fire drills. -She was not aware of Resident #4 leaving the facility on his own during monthly fire drills. Interview with a resident on 08/13/24 at 1:45pm revealed: -The facility would have fire drills twice a month. -When the fire alarm sounded the residents would exit out the front door or the back door and meet at the end of the driveway. -All residents would exit except for Resident #4, who had to be instructed by the staff to leave the facility. Interview with the Administrator on 08/13/24 at 2:00pm revealed:	C 022		

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C 022	Continued From page 4 -Resident #4 had dementia and needed assistance by the staff to care for himself. -Resident #4 needed encouraging to get out of bed and exit the facility during a fire drill. -Resident #4 had had a diagnosis of dementia when he was admitted to the facility. -Resident #4 was admitted to the facility in November 2022. -When Resident #4 was admitted he required instruction and assistance with activities of daily living, but she could not recall if he needed instruction with exiting the building during fire drills. Attempted interview with Resident #4's legal guardian on 08/13/24 at 2:30pm was unsuccessful. Attempted interview with Resident #4's PCP on 08/13/24 at 12:30pm was unsuccessful. _____ The facility failed to ensure the facility was equipped and maintained in accordance with the facility's licensed capacity to allow Resident #4 to reside in the facility, who had a diagnosis of dementia, was intermittently disoriented and needed instructions to evacuate independently in case of an emergency, such as a fire. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED September 27, 2024.	C 022		

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C 342	Continued From page 5	C 342		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3) including a medication for gastric reflux and a medication to increase blood flow. The findings are: Review of Resident #3's current FL-2 dated 2/22/24 revealed diagnoses included hypertension, hyperlipidemia, and chronic	C 342		

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C 342	Continued From page 6 obstructive pulmonary disease (COPD). a. Review for Resident #3's signed physician order dated 07/24/24 revealed there was an order for finasteride 5mg (used to treat acid reflux) daily. Review of Resident #3's August 2024 medication administration record (MAR) from 08/01/24 to 08/13/24 revealed: -There was no entry for finasteride 5mg to be administered daily. -There was no documentation finasteride 5mg was administered daily. Observation of Resident #3's medication on hand revealed: -There was a bubble pack of finasteride 5mg available for administration. -There were 30 finasteride 5mg tablets dispensed on 08/06/24 with 24 tablets remaining. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 08/13/24 at 12:54pm. Refer to the interview with the medication aide (MA) on 08/13/24 at 1:05pm. Refer to the interview with the Administrator on 08/13/24 at 1:30pm. b. Review of Resident #3's signed physician order dated 07/24/24 revealed there was an order for aspirin 81mg (used to increase blood flow) daily. Review of Resident #3's August 2024 medication administration record (MAR) from 08/01/24 to 08/13/24 revealed: -There was no entry for aspirin 81mg to be	C 342		

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C 342	Continued From page 7 administered daily. -There was no documentation aspirin 81mg was administered daily. Observation of Resident #3's medication on hand revealed: -There was a bubble pack of aspirin 81mg available for administration. -There were 30 aspirin 81mg tablets dispensed on 08/06/24 with 24 tablets remaining. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 08/13/24 at 12:54pm. Refer to the interview with the medication aide (MA) on 08/13/24 at 1:05pm. Refer to the interview with the Administrator on 08/13/24 at 1:30pm. _____ Telephone interview with a representative from the facility's contracted pharmacy on 08/13/24 at 12:54pm revealed: -The facility used paper MARs. -The pharmacy entered new orders into the computer for the facility. -New orders received during the month would be hand-written onto the MARs by the facility staff. -The pharmacy printed the paper MARs the last week of each month and took them to the facility. -August MARs were printed before the new medication orders were received by the pharmacy. -The new orders would show up on the next months, Septembers, MARs. -The facility staff was responsible for hand-writing new orders received the last week of the month onto the new month's MARs.	C 342		

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C 342	Continued From page 8 Interview with the medication aide (MA) on 08/13/24 at 1:05pm revealed: -She was responsible for checking the MARs at the end of the month to ensure all medications were listed on the MAR for the new month. -Resident #3 had two new medications ordered on 07/24/4; she hand-wrote them onto the July 2024 MAR. -She forgot to add the new medications to the August 2024 MAR when she reviewed the new MARs for August 2024. -She administered the medications to Resident #3, but failed to document they were administered because the medications were not on the August 2024 MAR. -She needed to make sure the MARs were accurate when administering medications. Interview with the Administrator on 08/13/24 at 1:30pm revealed: -She expected the MA to review the MARs and hand-write any new medications on the MAR until the pharmacy entered them into the computer. -She was concerned that the MAR would not be accurate when the Primary Care Provider (PCP) reviewed the MAR.	C 342		