PRINTED: 08/08/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL080004	A. BUILDING. _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY'S FAMILY CARE HOME	485 LONG FERRY ROAD SALISBURY, NC 28144

(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 07/30/24.	C 000		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) task of medication administration through injections was listed on the quarterly LHPS evaluation for 1 of 3 sampled residents (Resident #2).	C 254	[redacted] Family Care home was given the correct LHPS forms that we are now using for our patients. Our home nurse will be using the new forms	7/31/24

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Pamela M Holland — Administrator — 8/29/2024

"Reviewed and Acknowledged" CPP 9/9/2024

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C 254	Continued From page 1 The findings are: Review of Resident #2's current FL2 dated 09/28/23 revealed: -Diagnoses included schizoaffective disorder, osteoarthritis and hypertension. -There was an order for paliperidone palmitate (a medication used to treat schizoaffective disorder) inject 1.75 milliliters (ml) intramuscularly (IM) every three months. Review of Resident #2's LHPS evaluation dated 07/10/24 revealed: -Medication administration through injections was not listed as a marked task. -There were no LHPS tasks listed on the LHPS evaluation. Review of Resident #2's LHPS evaluation dated 04/10/24 revealed: -Medication administration through injections was not listed as a marked task. -There were no LHPS tasks listed on the LHPS evaluation. Interview with Resident #2 on 07/30/24 at 3:23pm revealed a mental health provider administered a medication by injection to her every three months. Telephone interview with the LHPS nurse on 07/30/24 at 2:27pm revealed: -She knew Resident #2 was administered medication through injections but she was not sure how often. -She did not know she needed to include medication administration through injections as a task on Resident #2's LHPS evaluation form if Resident #2 was administered injections outside the facility.	C 254		

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C 254	Continued From page 2 Interview with the Administrator on 06/05/24 at 6:03pm revealed: -She did not know medication administration through injections should be listed on the quarterly LHPS evaluation as an LHPS task for Resident #2. -She was responsible for ensuring all LHPS tasks were listed on LHPS evaluations.	C 254		
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	C 342	The documentation on the MAR has been corrected and the medication is being administered correctly as ordered 8/5/24 Our home Nurse will monitor all medication sheets.	

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C 342	Continued From page 3 medication administration records (MARs) were accurate for 1 of 3 sampled residents (#2) related to a medication used for thinning of the bones. The findings are: Review of Resident #2's current FL2 dated 09/28/23 revealed: -Diagnoses included schizoaffective disorder, osteoarthritis and osteoporosis. -There was an order for alendronate sodium (a medication used to treat osteoporosis) 70mg take 1 tablet weekly. Review of Resident #2's May 2024 medication administration record (MAR) revealed: -There was an entry for alendronate sodium 70mg take 1 tablet weekly. -There was documentation alendronate sodium 70mg was administered daily from 05/01/24 to 05/31/24. Review of Resident #2's June 2024 MAR revealed: -There was an entry for alendronate sodium 70mg take 1 tablet weekly. -There was documentation alendronate sodium 70mg was administered daily from 06/01/24 to 06/30/24. Review of Resident #2's July 2024 MAR from 07/01/24 to 07/30/24 revealed: -There was an entry for alendronate sodium 70mg take 1 tablet weekly. -There was documentation alendronate sodium 70mg was administered daily from 07/01/24 to 07/30/24. Observation of Resident #2's medications on hand on 07/30/24 at 1:00pm revealed:	C 342		

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C 342	Continued From page 4 -There was a monthly supply of medications that were rolled up and organized by the scheduled administration date. -There were 2 of 4 alendronate tablets available for administration with a filled date of 07/10/24 and a start date on the medication package of 07/17/24 and an end date of 08/15/24. Telephone interview with a representative from facility's contracted pharmacy on 07/30/24 at 2:20pm revealed: -There was a current order on file for alendronate 70mg take one tablet weekly for Resident #2. -Alendronate 70mg was dispensed to the facility for Resident #2 on 05/07/24 with a quantity of 5 tablets, 06/11/24 with a quantity of 4 tablets, and 07/10/24 with a quantity of 4 tablets. -The pharmacy sometimes filled medications a few days before medications were dispensed to the facility. -The pharmacy printed the MARs monthly for Resident #2. Interview with Resident #2 on 07/30/24 at 3:23pm revealed she was administered medications but she was not sure which of her medications was for osteoporosis. Interview with the Administrator on 07/30/24 at 1:42pm revealed: -Alendronate was documented daily on the MAR instead of weekly as ordered. -She documented alendronate administration incorrectly on the MAR, but the medication was administered weekly as ordered. -There were only four alendronate tablets dispensed from the pharmacy when alendronate was last dispensed which was a four-week supply. -She administered and documented all	C 342		

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C 342	Continued From page 5 medications for Resident #2. -She was responsible to administer and document medications as ordered.	C 342		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure record of the receipt and administration of controlled substances were maintained and accurate for 1 of 1 sampled residents (#2) related to an anti-anxiety medication. The findings are: Review of Resident #2's current FL2 dated 09/28/23 revealed: -Diagnoses included schizoaffective disorder, osteoarthritis and hypertension. -There was an order for clonazepam (a medication used to treat anxiety) 1mg take 1 tablet at bedtime as needed (PRN). Review of Resident #2's medication administration record (MAR) for May 2024 revealed: -There was an entry for clonazepam 1mg take 1 tablet at bedtime PRN scheduled for administration at 8:00pm.	C 367	We at [redacted] family care home are now using a controlled substance count sheet documenting receipt, administration and disposition of controlled substances. Our Home Nurse will monitor our count sheet	7/31/2024

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C 367	Continued From page 6 -There was documentation clonazepam was administered every night from 05/01/24 to 05/31/24. Review of Resident #2's MAR for June 2024 revealed: -There was an entry for clonazepam 1mg take 1 tablet at bedtime PRN scheduled for administration at 8:00pm. -There was documentation clonazepam was administered every night from 06/01/24 to 06/30/24. Review of Resident #2's MAR for July 2024 revealed: -There was an entry for clonazepam 1mg take 1 tablet at bedtime PRN scheduled for administration at 8:00pm. -There was documentation clonazepam was administered every night from 07/01/24 to 07/29/24. Review of Resident #2's Controlled Substance Count Sheets (CSCS) revealed there were no CSCS available for review for Resident #2's clonazepam. Observation of Resident #2's medications on hand on 07/30/24 at 1:00pm revealed: -There was a monthly supply of medications that were rolled up and organized by the scheduled administration date. -There were 17 of 30 clonazepam tablets available for administration with a filled date of 07/10/24 and a start date on the medication package of 07/17/24 and an end date of 08/15/24. Interview with Resident #2 on 07/30/24 at 3:23pm revealed she knew she was administered	C 367		

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C 367	Continued From page 7 clonazepam by staff and she was administered clonazepam at night. Telephone interview with a representative from facility's contracted pharmacy on 07/30/24 at 2:20pm revealed: -There was a current order on file for clonazepam 1mg take 1 tablet at bedtime PRN for Resident #2. -Clonazepam 1mg was dispensed to the facility for Resident #2 on 05/08/24, 06/11/24, and 07/15/24 with a quantity of 30 tablets for a 30 day supply each time. -The pharmacy sometimes filled medications a few days before medications were dispensed to the facility. -The pharmacy printed the MARs monthly for Resident #2. -She did not know and was not sure if the pharmacy printed CSCS for the facility when a controlled substance was dispensed. Interview with the Administrator on 07/30/24 at 1:42pm revealed: -There were no CSCS completed to match the medication administration of clonazepam for Resident #2. -She did not have a list of controlled substances to help her identify medications that were considered controlled substances. -The pharmacy did not send CSCS for the facility to document controlled substance administration and receipt. -Clonazepam was packaged with the rest of Resident #2's medications and she did not know clonazepam was a controlled substance. -She was responsible for maintaining a record of receipt and administration of controlled substances.	C 367		