STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001113	A. BUILDING: _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WE CARE FAMILY CARE	1718 MORGANTON ROAD BURLINGTON, NC 27217

(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 on September 10, 2024.	C 000		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or moving into a family care home, the administrator, all other staff, and any persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. (b) There shall be documentation on file in the family care home that the administrator, all other staff, and any persons living in the family care home are free of tuberculosis disease. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 3 of 3 sampled resident (#1, #2, and #3) had completed two-step tuberculosis (TB) testing in compliance with the control measures of the Commission for Health Services. The findings are: 1. Review of Resident #1's current FL-2 dated 08/12/24 revealed diagnoses included hypertension, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease (GERD), severe right hip pain, acute pancreatitis, and end-stage renal disease. Review of Resident #1's Resident Register	C 140		

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C 140	Continued From page 1 revealed an admission date of 05/08/23. Review of Resident #1's record on 09/10/24 at 9:30am revealed there was no TB testing available for review. Interview with Resident #1 on 09/10/24 at 10:00am revealed: -He thought he had a TB test, but he was not sure. -He thought he had a TB test at the primary care provider's (PCP) office. Attempted interviews with Resident #3's PCP on 09/10/24 at 2:00pm and 3:48pm was unsuccessful. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm. 2. Review of Resident #2's current FL-2 dated 08/12/24 revealed diagnoses included gastrointestinal bleeding, diabetes mellitus type 2, hypertension, chronic obstructive pulmonary disease (COPD), left below the knee amputation, blindness, and diabetic neuropathy. Review of Resident #2's Resident Register revealed an admission date of 08/11/23. Review of Resident #2's record on 09/10/24 at 10:15am revealed there was no TB testing available for review. Interview with Resident #2 on 09/10/24 at	C 140		

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C 140	Continued From page 2 12:20pm revealed he did not know if he received a TB test or not when he was admitted to the facility. Attempted interviews with Resident #3's primary care provider (PCP) on 09/10/24 at 2:00pm and 3:48pm was unsuccessful. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm. 3. Review of Resident #3's current FL-2 dated 03/12/24 revealed diagnoses included coronary artery disease, dementia, and diabetes mellitus type 2. Review of Resident #3's Resident Register revealed an admission date of 05/22/21. Review of Resident #3's tuberculosis (TB) skin test revealed: -A TB skin test was completed on 06/28/22 and the results were negative. -There was not a second TB skin test in Resident #3's record to review. Attempted interviews with Resident #3's primary care provider (PCP) on 09/10/24 at 2:00pm and 3:48pm was unsuccessful. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Based on observations, interviews, and record	C 140		

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C 140	Continued From page 3 reviews it was determined Resident #3 was not interviewable. Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm. _____ Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm revealed: -She thought the TB test were to be given once a year. -She did not know each resident needed two TB test within the first year. -She was sure the previous Administrator saw that each resident had two TB test the first year of admission to the facility. -She did not know where the results of the TB test were.	C 140		
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. 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 2 of 3 sampled residents (#1 and #2) related to a medication for gastric reflux and a medication for pain (#1) and a	C 330		

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medication for high cholesterol, two blood thinners, and two supplements (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 08/12/24 revealed diagnosis included gastro-esophageal reflux disease and severe right hip pain.

a. Review of Resident #1's current FL-2 dated 08/12/24 revealed there was an order for pantoprazole (used to treat reflux) 40mg daily.

Review of Resident #1's signed physician's order dated 07/15/24 revealed there was an order for pantoprazole 40mg twice daily.

Review of Resident #1's July 2024 medication administration record (MAR) from 07/15/24 to 07/31/24 revealed:
-There was an entry for pantoprazole 40mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation pantoprazole was administered twice daily from 07/15/24 to 07/24/24 and from 07/26/24 to 07/31/24.
-There was no documentation on 07/25/24; the MAR was blank.

Review of Resident #1's August 2024 MAR revealed:
-There was an entry for pantoprazole 40mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation pantoprazole was administered twice daily from 08/01/24 to 08/30/24.

Review of Resident #1's September 2024 MAR

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C 330	Continued From page 5	C 330		

from 09/01/24 to 09/10/24 revealed:
-There was an entry for pantoprazole 40mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation pantoprazole was administered twice daily from 09/01/24 to 09/09/24 and on 09/10/24 at 8:00am.

Observation of Resident #1's medication on hand on 09/10/24 at 10:09am revealed:
-There was a 7-day multi-dose pack which contained pantoprazole 40mg in the morning and night dose pack.
-The pharmacy dispensed four 7-day multi-dose pack monthly.
-The direction on the pantoprazole 40mg bubble pack was twice daily.

Interview with Resident #1 on 09/10/24 at 10:00am revealed:
-He took medication twice a day for his stomach discomfort.
-He had heart burn and had a gastrointestinal bleed a few years ago.
-He did not have any stomach discomfort now.

Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed:
-The pharmacy had an order for pantoprazole 40mg twice daily dated 07/15/24.
-The pantoprazole was dispensed in a 7-day multi-dose pack and the pharmacy dispensed four 7-day multi-dose packs every month.
-The pharmacy did not receive an order to decrease pantoprazole 40mg daily.
-The pharmacy did not receive Resident #2's FL-2 dated 08/12/24.

Interview with the Supervisor-in-Charge (SIC) on

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C 330	Continued From page 6 09/10/24 at 4:15pm revealed: -She did not realize she documented the wrong frequency for pantoprazole 40mg on the FL-2. -Pantoprazole was being administered twice daily because the pharmacy was placing the medication in the multi-dose pack. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm. Refer to the interview with the SIC on 09/10/24 at 4:15pm. b. Review of Resident #1's signed physician's order dated 09/04/24 revealed there was an order for methocarbamol 500mg (used to treat pain) daily. Review of Resident #1's September 2024 MAR from 09/04/24 to 09/10/24 revealed: -There was an entry for methocarbamol 500mg every 12 hours as needed for back pain. -There was no documentation methocarbamol 500mg had been administered from 09/04/24 to 09/10/24. Observation of Resident #1's medication on hand on 09/10/24 at 10:09am revealed: -There was a bubble pack of methocarbamol 500mg available for administration with a dispensed date of 09/04/24. -The pharmacy dispensed 14 methocarbamol 500mg. -There were 14 methocarbamol 500mg remaining in the bubble pack.	C 330		

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C 330	Continued From page 7 -The directions on the methocarbamol bubble pack were one daily. Interview with Resident #1 on 09/10/24 at 10:00am revealed: -He took methocarbamol for muscle spasms and pain. -He took methocarbamol as needed. -He requested the medication frequently. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed: -The pharmacy had an order for methocarbamol 500mg daily signed on 09/04/24, -The pharmacy dispensed 14 methocarbamol 500mg tablets on 09/04/24. -The pharmacy sent 14 tablets in a bubble pack until the facility next cycle date was to start. -Once the next cycle started, the methocarbamol would be in the multi-dose pack. Interview with the SIC on 09/10/24 at 4:15pm revealed: -She received the medications from the pharmacy and checked them in. -She knew Resident #1 received methocarbamol 500mg daily a few weeks ago. -She did not have an order for methocarbamol 500mg daily, so she did not administer the medication. -She did not call the pharmacy to see why the medication was sent without an order. -She did not know the pharmacy had the order for methocarbamol 500mg daily. -She should have called the pharmacy when she received the medication and did not have an order for the medication. Attempted telephone interview with the	C 330		

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C 330	Continued From page 8 Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm. Refer to the interview with the SIC on 09/10/24 at 4:15pm. 2. Review of Resident #2's current FL-2 dated 08/12/24 revealed diagnoses included acute gastrointestinal bleeding, acute blood loss, diabetes mellitus type 2, hypertension, chronic obstructive pulmonary disease (COPD), left below the knee amputation, blindness, and diabetic neuropathy. a. Review of Resident #2's current FL-2 dated 08/12/24 revealed there was no order for atorvastatin (used to lower cholesterol) 80mg daily. Review of Resident #2's signed physician's order dated 02/03/24 revealed there was an order for atorvastatin 80mg daily. Review of Resident #2's August 2024 medication administration record (MAR) from 08/12/24 to 08/30/24 revealed: -There was an entry for atorvastatin 80mg daily with a scheduled administration time of 8:00am. -There was documentation atorvastatin was administered at 8:00am from 08/12/24 to 08/31/24. Review of Resident #2's September 2024 MAR from 09/01/24 to 09/10/24 revealed: -There was an entry for atorvastatin 80mg daily with a scheduled administration time of 8:00am.	C 330		

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C 330	Continued From page 9 -There was documentation atorvastatin was administered at 8:00am from 09/01/24 to 09/10/24. Observation of Resident #2's medication on hand on 09/10/24 at 10:48am revealed: -There was a 7-day multi-dose pack which contained atorvastatin 80mg in the morning dose pack. -The pharmacy dispensed four 7-day multi-dose packs monthly. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed: -The pharmacy had an order for atorvastatin 80mg daily dated 02/03/24. -The atorvastatin was dispensed in a 7-day multi-dose pack and the pharmacy dispensed four 7-day multi-dose packs every month. -The pharmacy did not receive an order to discontinue atorvastatin. -The pharmacy did not receive Resident #2's FL-2 dated 08/12/24. Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm revealed: -She did not realize she left atorvastatin 80mg off the current FL-2. -Atorvastatin was still being administered because the pharmacy was placing the medication in the multi-dose pack. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm.	C 330		

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C 330	Continued From page 10 Refer to the interview with the SIC on 09/10/24 at 4:15pm. b. Review of Resident #2's current FL-2 dated 08/12/24 revealed there was no order for clopidogrel 75mg (used to prevent blood clots) daily before breakfast. Review of Resident #2's signed physician's order dated 02/03/24 revealed there was an order for clopidogrel 75mg daily. Review of Resident #2's August 2024 MAR from 08/12/24 to 08/30/24 revealed: -There was an entry for clopidogrel 7.5mg daily with breakfast with a scheduled administration time of 8:00am. -There was documentation clopidogrel was administered at 8:00am from 08/12/24 to 08/30/24. Review of Resident #2's September 2024 MAR from 09/01/24 to 09/10/24 revealed: -There was an entry for clopidogrel 7.5mg daily with breakfast with a scheduled administration time of 8:00am. -There was documentation clopidogrel was administered at 8:00am from 09/01/24 to 09/10/24. Observation of Resident #2's medication on hand on 09/10/24 at 10:48am revealed: -There was a 7-day multi-dose pack which contained clopidogrel 7.5mg in the morning dose pack. -The pharmacy dispensed four 7-day multi-dose packs monthly. Telephone interview with a representative from	C 330		

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the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed:
-The pharmacy had an order for clopidogrel 7.5mg daily dated 02/03/24.
-The clopidogrel was dispensed in a 7-day multi-dose pack and the pharmacy dispensed four 7-day multi-dose packs every month.
-The pharmacy did not receive an order to discontinue clopidogrel.
-The pharmacy did not receive Resident #2's FL-2 dated 08/12/24.

Interview with the SIC on 09/10/24 at 4:15pm revealed:
-She did not realize she left clopidogrel 7.5mg off the current FL-2.
-Clopidogrel 7.5mg was still being administered because the pharmacy was placing the medications in the multi-dose pack.

Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm.

Refer to the interview with the SIC on 09/10/24 at 4:15pm.

c. Review of Resident #2's current FL-2 dated 08/12/24 revealed there was no order for aspirin 81mg (used to treat heart disease) daily.

Review of Resident #2's signed physician's order dated 02/03/24 revealed there was an order for aspirin 81mg daily.

Review of Resident #2's August 2024 MAR from

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C 330	Continued From page 12 08/12/24 to 08/30/24 revealed: -There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation aspirin was administered at 8:00am from 08/12/24 to 08/31/24. Review of Resident #2's September 2024 MAR from 09/01/24 to 09/10/24 revealed: -There was an entry for aspirin 81mg daily with a scheduled administration time of 8:00am. -There was documentation aspirin was administered at 8:00am from 09/01/24 to 09/10/24. Observation of Resident #2's medication on hand on 09/10/24 at 10:48am revealed: -There was a 7-day multi-dose pack which contained aspirin 81mg in the morning dose pack. -The pharmacy dispensed four 7-day multi-dose packs monthly. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed: -The pharmacy had an order for aspirin 81mg daily dated 02/03/24. -The aspirin was dispensed in a 7-day multi-dose pack and the pharmacy dispensed four 7-day multi-dose packs every month. -The pharmacy did not receive an order to discontinue aspirin. -The pharmacy did not receive Resident #2's FL-2 dated 08/12/24. Interview with the SIC on 09/10/24 at 4:15pm revealed: -She did not realize she left aspirin 81mg off the current FL-2.	C 330		

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C 330	Continued From page 13 -Aspirin 81mg was still being administered because the pharmacy was placing the medications in the multi-dose pack. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm. Refer to the interview with the SIC on 09/10/24 at 4:15pm. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. d. Review of Resident #2's current FL-2 dated 08/12/24 revealed there was no order for ferrous gluconate 240mg (used as a supplement) daily. Review of Resident #2's signed physician's order dated 05/16/24 revealed there was an order for ferrous gluconate 240mg daily. Review of Resident #2's August 2024 MAR from 08/12/24 to 08/30/24 revealed: -There was an entry for ferrous gluconate 240mg daily with a scheduled administration time of 8:00am. -There was documentation ferrous gluconate was administered at 8:00am from 08/12/24 to 08/31/24. Review of Resident #2's September 2024 MAR from 09/01/24 to 09/10/24 revealed: -There was an entry for ferrous gluconate 240mg daily with a scheduled administration time of 8:00am. -There was documentation ferrous gluconate was administered at 8:00am from 09/01/24 to 09/10/24.	C 330		

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C 330	Continued From page 14 Observation of Resident #2's medication on hand on 09/10/24 at 10:48am revealed: -There was a 7-day multi-dose pack which contained ferrous gluconate 240mg in the morning dose pack. -The pharmacy dispensed four 7-day multi-dose packs monthly. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed: -The pharmacy had an order for ferrous gluconate 240mg daily dated 02/03/24. -The ferrous gluconate was dispensed in a 7-day multi-dose pack and the pharmacy dispensed four 7-day multi-dose packs every month. -The pharmacy did not receive an order to discontinue ferrous gluconate. -The pharmacy did not receive Resident #2's FL-2 dated 08/12/24. Interview with the SIC on 09/10/24 at 4:15pm revealed: -She did not realize she left ferrous sulfate 240mg off the current FL-2. -Ferrous sulfate was still being administered because the pharmacy was placing the medications in the multi-dose pack. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm. Refer to the interview with the SIC on 09/10/24 at 4:15pm.	C 330		

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C 330	Continued From page 15 e. Review of Resident #2's current FL-2 dated 08/12/24 revealed there was no order for vitamin B12 1000mcg (used as a supplement daily. Review of Resident #2's signed physician's order dated 02/03/24 revealed there was an order for vitamin B-12 1000mcg daily. Review of Resident #2's August 2024 MAR from 08/12/24 to 08/30/24 revealed: -There was an entry for vitamin B-12 1000mcg daily with a scheduled administration time of 8:00am. -There was documentation vitamin B-12 was administered daily at 8:00am from 08/12/24 to 08/31/24. Review of Resident #2's September 2024 MAR from 09/01/24 to 09/10/24 revealed: -There was an entry for vitamin B-12 1000mcg daily with a scheduled administration time of 8:00am. -There was documentation vitamin B-12 was administered daily at 8:00am from 09/01/24 to 09/10/24. Observation of Resident #2's medication on hand on 09/10/24 at 10:48am revealed: -There was a 7-day multi-dose pack which contained vitamin B-12 1000mcg in the morning dose pack. -The pharmacy dispensed four 7-day multi-dose packs monthly. Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed: -The pharmacy had an order for vitamin B-12 1000mcg daily dated 02/03/24.	C 330		

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C 330	Continued From page 16 -The vitamin B-12 was dispensed in a 7-day multi-dose pack and the pharmacy dispensed four 7-day multi-dose packs every month. -The pharmacy did not receive an order to discontinue vitamin B-12. -The pharmacy did not receive Resident #2's FL-2 dated 08/12/24. Interview with the SIC on 09/10/24 at 4:15pm revealed: -She did not realize she left vitamin B-12 1000mcg off the current FL-2. -Vitamin B-12 was still being administered because the pharmacy was placing the medications in the multi-dose pack. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm. Refer to the interview with the SIC on 09/10/24 at 4:15pm. _____ Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed: -The facility was on cycle fill. -The last cycle was dispensed on 08/16/24; the next cycle was due to be dispensed in a few days. -The facility was responsible for faxing new FL-2's to the pharmacy. -The pharmacy would review the new FL-2 for accuracy and if there was something different on the FL-2 than what was being currently administered, the pharmacy would notify the	C 330		

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C 330	Continued From page 17 primary care provider (PCP). Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm revealed: -She completed the annual FL-2s for the PCP for the residents. -She referred to the medication administration record (MAR), the previous FL-2, and any orders written by the PCP. -She took the FL-2 to the PCPs office for signature. -She did not fax the FL-2 to the pharmacy; she did not know she needed too. -The medications were still being administered because the pharmacy was placing the medications in the multi-dose pack.	C 330		
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	C 342		

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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 2 of 3 sampled residents (#1 and #2) including a medication patch (#1) and a dietary supplement (#2).

The findings are:

1. Review of Resident #1's current FL-2 dated 08/12/24 revealed:
-Diagnoses included hypertension, chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux disease (GERD), severe right hip pain, acute pancreatitis, and end-stage renal disease.
-There was no order for Aspercreme Lidocaine 4% (used to treat localized pain) patch apply one patch every 12 hours.

Review of Resident #1's signed physician's order dated 07/18/24 revealed there was an order to discontinue Aspercreme Lidocaine patch due to Resident #1's refusal of the medication.

Review of Resident #1's September 2024 medication administration record (MAR) from 09/01/24 to 09/10/24 revealed:
-There was an entry for Aspercreme Lidocaine patch 4% apply to skin every 12 hours with a scheduled administration time of 8:00am.
-There was documentation Aspercreme Lidocaine patch was applied every morning from 09/01/24 to 09/10/24 at 8:00am.

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C 342	Continued From page 19 Interview with Resident #1 on 09/10/24 at 10:00am revealed: -His primary care provider (PCP) ordered the patches to be placed on his back for pain. -The patches did not help with the pain, so he asked his PCP to discontinue the patches. -He had not worn the medicated patch in months. Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm revealed: -Resident #1's Aspercreme Lidocaine patch had been discontinued because Resident #1 was refusing the patch. -She did not realize the entry for Aspercreme Lidocaine patch was still on the MARs. -She documented incorrectly that she administered the Aspercreme Lidocaine path. -She did not administer the Lidocaine patch; Resident #1 did not have any Aspercreme Lidocaine patches to administer. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm. 2. Review of Resident #2's current FL-2 dated 08/12/24 revealed diagnoses included gastrointestinal bleeding, diabetes mellitus type 2, hypertension, chronic obstructive pulmonary disease (COPD), left below the knee amputation, blindness, and diabetic neuropathy. Review of Resident #2's signed physician's order dated 07/11/24 revealed there was an order for Vitamin D2 50,000 units (used to treat vitamin D deficiency) every 7 days.	C 342		

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C 342	Continued From page 20 Review of Resident #2's July 2024 medication administration record (MAR) from 07/11/24 to 07/31/24 revealed: -There was an entry for vitamin D2 50,000 units every 7 days with a scheduled administration time of 8:00am. -There was documentation vitamin D2 was administered daily from 07/11/24 to 07/31/24. Review of Resident #2's August 2024 MAR revealed: -There was an entry for vitamin D2 50,000 units every 7 days with a scheduled administration time of 8:00am. -There was documentation vitamin D2 was administered daily from 08/01/24 to 08/31/24. Review of Resident #2's September 2024 MAR from 09/01/24 to 09/10/24 revealed: -There was an entry for vitamin D2 50,000 units every 7 days from 09/01/24 to 09/10/24 with a scheduled administration time of 8:00am. -There was documentation vitamin D2 was administered daily from 09/01/24 to 09/10/24. Interview with Resident #2 on 09/10/24 at 12:20pm revealed: -He was administered a handful of pills each morning. -He did not recall taking a vitamin D2 daily, but he was not sure. Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm revealed Resident #2 only received 1 vitamin D2 50,000 units weekly as dispensed by the pharmacy in the multi-dose packs. Attempted telephone interview with the	C 342		

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C 342	Continued From page 21 Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm. _____ Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm revealed: -She had not noticed she was documenting incorrectly on the MARs. -She needed to pay more attention to the MARs when she documented administration of medications.	C 342		
C 368	10A NCAC 13G .1008 (b) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure the controlled medication was stored under double lock for 2 of 2 sampled residents (#1 and #3) including a medication for pain (#1) and an anti-anxiety medication (#3). The findings are: Observation of the medication cabinet on 09/10/24 from 9:30am to 4:00pm revealed:	C 368		

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-The doors to the medication cabinet were unlocked.
-There was a black locked box inside the medication cabinet, that was unlocked.
-The black box contained controlled medications.

1. Review of Resident #1's current FL-2 dated 08/12/24 revealed diagnoses included severe right hip pain, acute pancreatitis, and end-stage renal disease.

Review of Resident #1's signed physician's order dated 08/13/24 revealed there was an order for oxycodone 10mg twice daily.

Observation of Resident #1's medication on 09/10/24 at 10:09am revealed:
-Resident #1 had a bubble pack of oxycodone 10mg available for administration.
-The oxycodone was in the unlocked, black box inside the unlocked medication cabinet.

Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm.

Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm.

2. Review of Resident #3's current FL-2 dated 03/12/24 revealed diagnoses included coronary artery disease, dementia, and diabetes mellitus type.

a. Review of Resident #3's signed physician's

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C 368	Continued From page 23 order dated 07/26/24 revealed there was an order for valium 2mg (used to treat anxiety) three times daily. Observation of Resident #3's medication on 09/10/24 at 10:48am revealed: -Resident #3 had a bubble pack of valium 2mg available for administration. -The valium was in the unlocked, black box inside the unlocked medication cabinet. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm. Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm b. Review of Resident #3's signed physician's order dated 07/26/24 revealed there was an order for valium 5mg (used to treat anxiety) at bedtime. Observation of Resident #3's medication on 09/10/24 at 10:45am revealed: -Resident #3 had a bubble pack of valium 5mg available for administration. -The valium was in the unlocked, black box inside the unlocked medication cabinet. Attempted telephone interview with the Administrator on 09/10/24 at 4:00pm was unsuccessful. Refer to the telephone interview with a representative from the facility's contracted	C 368		

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C 368	Continued From page 24 pharmacy on 09/10/24 at 1:22pm. Refer to the interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm. _____ Telephone interview with a representative from the facility's contracted pharmacy on 09/10/24 at 1:22pm revealed: -Controlled substances were required to be secured under double lock. -Controlled substances could be abused and addictive. Interview with the Supervisor-in-Charge (SIC) on 09/10/24 at 4:15pm revealed: -She knew controlled substances should be double locked. -The medications were kept in the medication cabinet which had a lock. -There was a black, locked box in the medication cabinet for controlled substances. -She thought the medication cabinet and the black boxed were locked. -She did not know the medication cabinet and the black boxed had been unlocked all day. -The medication cabinet and the black box should be locked when medications were not being administered.	C 368		