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
	FCL035029	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER HEALTHCARE #2	113 JUSTICE STREET LOUISBURG, NC 27549

(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 and the Franklin County Department of Social Services conducted an annual survey and a follow-up survey on 08/22/24.	C 000	The administrator has communicated to the pharmacy about the duplication of orders. Carter Clinic has since discontinued the clozapine 50mg as of 8/22/24	
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to clarify an order for 1 of 3 sampled residents (#2) related to an antipsychotic medication. The findings are: Review of Resident #2's current FL-2 dated 07/08/24 revealed: -Diagnoses included schizoaffective disorder, bipolar, schizophrenia, obsessive compulsive disorder (OCD), hyperlipidemia, hypothyroidism, and traumatic brain injury. -There was an order for clozapine (used to treat schizophrenia) 25mg, two tablets, in the evening.	C 315	C315 Addendum per telephone conversation with the Administrator on 09/26/24 revealed: The Administrator will monitor bi-weekly for two months and monthly for three months. Completion date 09/15/24. PD 09/26/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bridget Dunn — TITLE: administrator — (X6) DATE: 9/23/24

The Plan of Correction with addendum was reviewed and acknowledged on 09/26/24.
Refer to addendum on page 1 of this Statement of Deficiencies.

PD 09/26/24

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C 315	Continued From page 1 -There was an order for clozapine 50mg, one tablet, in the morning. -There was an order for clozapine 200mg, one tablet twice daily. Review of Resident #2's medication administration record (MAR) for June 2024, July 2024 and August 2024 from 08/01/24 to 08/20/24 revealed: -There was an entry for clozapine 25mg two tablets in the evening scheduled at 8:00pm; clozapine 25mg was documented as administered every evening at 8:00pm. -There was an entry for clozapine 50mg one tablet in the morning scheduled at 8:00am; clozapine 50mg was documented as administered every morning at 8:00am. -There was an entry for clozapine 200mg one tablet twice daily scheduled at 8:00am and 8:00pm; clozapine 200mg was documented as administered twice daily. Observation of Resident #2's medication on hand on 08/22/24 at 11:28am revealed: -There was a medication card of 60 tablets of clozapine 25mg two tablets at bedtime dispensed on 05/11/24; there were 60 tablets available for administration. -There was a medication card of 60 tablets of clozapine 25mg two tablets at bedtime dispensed on 07/12/24; there were 16 tablets available for administration. -There were two medication cards of 30 tablets in each card of clozapine 200mg one tablet twice daily dispensed on 08/08/24 labeled 1 of 2 and a 2 of 2; there were 28 tablets in the card labeled 1 of 2 and 23 tablets in the card labeled 2 of 2 available for administration. -There were no medication cards with clozapine 50mg in the morning available for administration.	C 315		

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C 315	Continued From page 2 Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/22/24 at 1:24pm revealed: -There was no discontinue order for the clozapine 50mg once daily. -The pharmacy was attempting to contact the prescribing physician to try to get a discontinued order for the 50mg once daily. -The was no documentation of the date the pharmacy attempted to contact the physician for the discontinue order. -There were two different orders from two different physicians for Resident #2's clozapine. -Resident #2 should not have been on the morning dose of clozapine 50mg and the clozapine 200mg. -Clozapine was used to treat schizophrenia. Interview with Resident #2 on 08/22/24 at 3:49pm revealed: -He did not know the names of his medications, but he knew why he took different medications and what they were for. -He did not know if he took clozapine. Interview with the MA on 08/22/24 at 5:01pm revealed: -She did not realize all of Resident #2's clozapine were not available for administration. -She compared the MAR to the medication cards prior to administration. -If she had realized the clozapine 50mg was not available she would have called the pharmacy. -Resident #2 had morning and evening medication cards for his clozapine. Interviews with the Administrator on 08/22/24 at 12:02pm and 4:07pm revealed: -It looked like Resident #2 had duplicate orders	C 315		

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C 315	Continued From page 3 for his clozapine. -She thought the order for the clozapine 25mg was to replace the clozapine 50mg order. -The staff did not check the orders against the medications when they were delivered from the pharmacy. -The MAs compare the MAR to the medications prior to administering. -If the staff had alerted her when Resident #2's clozapine 50mg was not delivered or was not available to administer then she would have called the physician and gotten a discontinue order for the clozapine 50mg. Attempted telephone interview with Resident #2's mental health provider (MHP) on 08/22/24 at 4:24pm was unsuccessful.	C 315	- Medications are being administered as scheduled, the administrator had talked with the residents and all six of them stated that they count their medications and the count has always remained the same. The staff admitted to not documenting med administration on a timely manner. The administrator has since had an inservice on medication administration documentation as of 8/23/24. The administrator will continue to monitor the records at the group home to ensure compliance on biweekly basis.	
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, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) related to a high blood pressure medication, an antiseizure medication and an antidepressant (#2).	C 330		

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C 330	Continued From page 4 The findings are: Review of Resident #2's current FL-2 dated 07/08/24 revealed: -Diagnoses included schizoaffective disorder, bipolar, obsessive compulsive disorder (OCD), hyperlipidemia, hypothyroidism, and traumatic brain injury. -There was an order for divalproex (use to prevent convulsions) 250mg once in the evening. -There was an order for bupropion (used to treat depression) 100mg twice daily. -There was an order for prazosin (used to treat high blood pressure) 1mg once daily. Review of Resident #2's medication administration record (MAR) for June 2024 revealed: -There was an entry for divalproex 250mg, once daily scheduled at 7:30am. -There was documentation Resident #2 was administered divalproex daily from 06/01/24 to 06/30/24. -There was an entry for bupropion 100mg, twice daily scheduled at 8:00am and 4:00pm. -There was documentation bupropion was administered twice daily from 06/01/24 to 06/30/24. -There was an entry for prazosin 1mg, once daily scheduled at 8:00pm. -There was documentation bupropion was administered once daily from 06/01/24 to 06/30/24. Review of Resident #2's MAR July 2024 revealed: -There was an entry for divalproex 250mg, once daily scheduled at 7:30am. -There was documentation Resident #2 was administered divalproex daily from 07/01/24 to 07/31/24.	C 330		

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C 330	Continued From page 5 -There was an entry for bupropion 100mg, twice daily scheduled at 8:00am and 4:00pm. -There was documentation bupropion was administered twice daily from 07/01/24 to 07/31/24. -There was an entry for prazosin 1mg, once daily scheduled at 8:00pm. -There was documentation prazosin was administered once daily from 07/01/24 to 07/31/24. Review of Resident #2's MAR August 2024 from 08/01/24 to 08/20/24 revealed: -There was an entry for divalproex 250mg, once daily scheduled at 7:30am. -There was documentation Resident #2 was administered divalproex daily from 08/01/24 to 08/20/24. -There was an entry for bupropion 100mg, twice daily scheduled at 8:00am and 4:00pm. -There was documentation bupropion was administered twice daily from 08/01/24 to 08/20/24. -There was an entry for prazosin 1mg, once daily scheduled at 8:00pm. -There was documentation prazosin was administered once daily from 08/01/24 to 08/20/24. Observation of Resident #2's medication on hand on 08/22/24 at 11:28am revealed: -There was a medication card of 30 tablets of divalproex 250mg, administer once daily dispensed on 06/12/24; there were 6 tablets available for administration. -There was a medication card of 30 tablets of divalproex 250mg, administer once daily dispensed on 07/11/24; there were 30 tablets available for administration. -There was a medication card of 30 tablets of	C 330		

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C 330	Continued From page 6 divalproex 250mg, administer once daily dispensed on 08/11/24; there were 30 tablets available for administration. -There was a medication card with 60 tablets of bupropion 100mg, administer twice daily dispensed on 05/01/24; there were 9 tablets available for administration. -There were two medication cards each with 30 tablets of bupropion 100mg, administer twice daily dispensed on 01/15/24 labeled 1 of 2 and a 2 of 2; there were 30 tablets in each card available for administration. -There were two medication cards each with 30 tablets of bupropion 100mg, administer twice daily dispensed on 07/11/24 labeled 1 of 2 and a 2 of 2; there were 30 tablets in each card available for administration. -There was a medication card of prazosin 1mg, administer once daily dispensed on 05/11/24; there were 9 tablets available for administration. -There was a medication card of prazosin 1mg, administer once daily dispensed on 07/11/24; there were 30 tablets available for administration. -There was a medication card of prazosin 1mg, administer once daily dispensed on 08/11/24; there were 30 tablets available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/22/24 at 12:41pm revealed: -Medications were on a cycle fill and dispensed every thirty days. -If the residents were administered their medications as ordered there would not be extra cards with extra medications available. Telephone interview with a second pharmacist from the facility's contracted pharmacy on 08/22/24 at 1:24pm revealed: -Thirty tablets of divalproex were dispensed on	C 330		

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C 330	Continued From page 7 06/12/24, 07/11/24 and 08/11/24. -Divalproex was an antiseizure medication. -A thirty-day supply of sixty tablets of bupropion were dispensed every thirty days. -Bupropion was an antidepressant. -A thirty-day supply of thirty tablets of prazosin were dispensed on 05/11/24, 06/12/24, 07/12/24, and 08/13/24. -Prazosin was used to treat high blood pressure. Interview with Resident #2 on 08/22/24 at 3:49pm revealed: -He did not know the names of his medications, but he knew why he took different medications and what they were for. -He took a medication for depression and to prevent seizures. -Staff did not always give him his medications; sometimes they just forgot. -The previous medication aide (MA) worked at the facility for about three or four months and he forgot to give the residents their medications. Interview with the MA on 08/22/24 at 5:01pm revealed: -She had only started to work at the facility less than a week ago. -She had relieved another MA that had been at the facility for a couple of months. -She had not paid attention to the dates on the medication cards. -She knew there was an "overstock" bin with extra medications, but she had not looked at the dates on the cards. -She thought the overstock bin had medications that had been recently delivered by the pharmacy. Interviews with the Administrator on 08/22/24 at 12:02pm and 4:07pm revealed: -She knew the residents were getting their	C 330		

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C 330	Continued From page 8 medications as ordered because she came in once a week and interviewed them and asked if they had taken their medications; they always told her "yes". -The residents would not know what medications they took only she would know. -There were medication cards from January 2024 and May 2024 because the MAs had skipped over those cards to administer the new cards delivered by the pharmacy. -There should not have been medication cards from January 2024, May 2024 and June 2024 with medication available for administration for Resident #2. Attempted telephone interview with Resident #2's primary care provider (PCP) on 08/22/24 at 2:40pm was unsuccessful.	C 330	As of 8/23/24 the administrator has reviewed the rules and procedures about the med administration and medication documentation. Administrator will review records on biweekly basis to ensure compliance	
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the	C 341		

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C 341	Continued From page 9	C 341		

documentation of medication administration immediately following administration of medication to a resident and prior to administering medication to the next resident for 3 of 3 sampled residents (#1, #2, #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/25/24 revealed:
-Diagnoses included hypertension, coronary artery disease, schizoaffective disorder, bipolar, chronic bilateral lower swelling, and atrial fibrillation.
-There was an order for atorvastatin (used to lower high cholesterol) 80mg once daily.
-There was an order for our omeprazole (used to treat heartburn) 20mg once daily.
-There was an order for olanzapine (used to treat schizophrenia and bipolar disorder) 20mg once daily.
-There was an order for furosemide (used to treat edema) 20mg once daily.
-There was an order for lisinopril (used to treat high blood pressure) 20mg once daily.
-There was an order for Jardiance (used to treat diabetes)10mg once daily.
-There was an order for metoprolol (used to treat high blood pressure) 50mg once daily.
-There was an order for trazodone (used to treat depression) 50mg at bedtime.
-There was an order for apixaban (used to treat blood clots) 5mg twice daily.
-There was an order for benztropine (used to treat Parkinson's disease) 1mg twice daily.
-There was an order for divalproex (used to treat seizures) 500mg twice daily.

Review of Resident #1's August 2024 medication administration record (MAR) from 08/21/24 to

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C 341	Continued From page 10 08/22/24 revealed: -There was an entry for atorvastatin 80mg, once daily scheduled at 8:00am; there was no documentation atorvastatin 20mg was administered at 8:00am on 08/22/24. -There was an entry for omeprazole 20mg, once daily scheduled at 8:00am; there was no documentation omeprazole 20mg was administered on 08/22/24 at 8:00am. -There was an entry for olanzapine 20mg, once daily scheduled at 8:00am; there was no documentation olanzapine 20mg was administered on 08/22/24 at 8:00am. -There was an entry for furosemide 20mg, once daily scheduled at 8:00am; there was no documentation furosemide 20mg was administered on 08/22/24 at 8:00am. -There was an entry for lisinopril 20mg, once daily scheduled at 8:00am; there was no documentation lisinopril 20mg was administered on 08/22/24 at 8:00am. -There was an entry for Jardiance 10mg, once daily scheduled at 8:00am; there was no documentation Jardiance 10mg was administered on 08/22/24 at 8:00am. -There was an entry for metoprolol 50mg, once daily scheduled at 8:00pm; there was no documentation metoprolol 50mg was administered on 08/21/24 at 8:00pm. -There was an entry for trazodone 50mg, once daily scheduled at 8;00pm; there was no documentation trazodone 50mg was administered on 08/21/24 at 8:00pm. -There was an entry for apixaban 5mg, twice daily scheduled at 8:00am and 8:00pm; there was no documentation apixaban was administered on 08/21/24 and 08/22/24. -There was an entry for benztropine 1mg, twice daily scheduled at 8:00am and 8:00pm; there was no documentation benztropine 1mg was	C 341		

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C 341	Continued From page 11 administered on 08/21/24 and 08/22/24. -There was an entry for divalproex 500mg, twice daily scheduled at 8:00am and 8:00pm; there was no documentation divalproex was administered on 08/21/24 and 08/22/24. Refer to the interviews with the MA on 08/22/24 at 8:26am and 5:01pm. Refer to the interview with the Administrator on 08/22/24 at 12:45pm. 2. Review of Resident #2's current FL-2 dated 07/08/24 revealed: -Diagnoses included schizoaffective disorder, bipolar, obsessive compulsive disorder (OCD), hyperlipidemia, hypothyroidism, and traumatic brain injury. -There was an order for levothyroxine (used to treat hypothyroidism) 25mcg once daily. -There was an order for loratadine (used to treat allergy symptoms) 10mg once daily. -There was an order for ondansetron (used to treat nausea) 4mg once daily. -There was an order for levocarnitine (used to treat kidney disease) 330mg three times daily. -There was an order for divalproex (use to prevent convulsions) 250mg once in the evening. -There was an order for trazodone (used to treat depression) 100mg at bed time. -There was an order for omega-3 (used to lower triglycerides in the blood) 1gm twice daily. -There was an order for bupropion (used to treat depression) 100mg twice daily. -There was an order for sertraline (used to treat obsessive compulsive disorder) 100mg twice	C 341		

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C 341	Continued From page 12 daily. Review of Resident #2's August 2024 medication administration record (MAR) from 08/21/24 to 08/22/24 revealed: -There was an entry for levothyroxine 25mcg, once daily scheduled at 8:00am; there was no documentation levothyroxine was administered on 08/22/24. -There was an entry for loratadine 10mg, once daily scheduled at 8:00am; there was no documentation loratadine was administered on 08/22/24. -There was an entry for ondansetron 4mg, once daily scheduled at 8:00am; there was no documentation ondansetron was administered on 08/22/24. -There was an entry for levocarnitine 330mg, three times daily scheduled at 8:00am, 2:00pm and 8:00pm; there was no documentation levocarnitine was administered on 08/21/24 and 08/22/24. -There was an entry for divalproex 250mg, once daily scheduled at 7:30am; there was no documentation divalproex was administered on 08/22/24. -There was an entry for trazadone100mg, once daily scheduled at 8:00pm; there was no documentation trazadone was administered on 08/21/24. -There was an entry for omega-3 1gm, twice daily scheduled at 8:00am and 8:00pm; there was no documentation omega-3 was administered on 08/21/24 and 08/22/24. -There was an entry for bupropion 100mg, twice daily scheduled at 8:00am and 4:00pm; there was no documentation bupropion was administered on 08/21/24 and 08/22/24. -There was an entry for sertraline 100mg, twice daily scheduled at 8:00am and 8:00pm; there was	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035029	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 341	Continued From page 13 no documentation sertraline was administered on 08/21/24 and 08/22/24. Interview with Resident #2 on 08/22/24 at 3:49pm revealed: -He did not know his medications, but he could look at his MAR and see what he took. -He was administered his medications the day before, 08/21/24 and today, 08/22/24. Refer to the interviews with the MA on 08/22/24 at 8:26am and 5:01pm. Refer to the interview with the Administrator on 08/22/24 at 12:45pm. 3. Review of Resident #3's current FL-2 dated 03/27/24 revealed: -Diagnoses included schizophrenia, chronic pain, gastroesophageal disease (GERD), hypertension, coronary artery disease, and chronic kidney disease. -There was an order for trazadone (used to treat depression) 250mg at bedtime. -There was an order for benztropine (used to treat Parkinson's disease)1mg twice daily. -There was an order for carvedilol (used to treat high blood pressure) 25mg twice daily. -There was an order for vitamin D3 (a supplement used to treat vitamin D deficiency) 50mcg once daily. -There was an order for fluphenazine (used to treat schizophrenia) 10mg twice daily. Review of Resident #3's August 2024 medication administration record (MAR) from 08/21/24 to 08/22/24 revealed: -There was an entry for trazadone 250mg, once daily scheduled at 8:00pm; there was no documentation trazadone was administered on 08/21/24.	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035029	A. BUILDING: _____ B. WING _____	08/22/2024

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C 341	Continued From page 14 -There was an entry for benztropine 1mg, twice daily scheduled at 8:00am and 8:00pm; there was no documentation benztropine was administered on 08/21/24 and 08/22/24. -There was an entry for carvedilol 25mg, twice daily scheduled at 8:00am and 8:00pm; there was no documentation carvedilol was administered on 08/21/24 and 08/22/24. -There was an entry for vitamin D3 50mcg, once daily scheduled at 8:00am; there was no documentation vitamin D3 was administered on 08/21/24 and 08/22/24. -There was an entry for fluphenazine 10mg, twice daily scheduled at 8:00am and 8:00pm; there was not documentation fluphenazine was administered on 08/21/24 and 08/22/24. Refer to the interviews with the MA on 08/22/24 at 8:26am and 5:01pm. Refer to the interview with the Administrator on 08/22/24 at 12:45pm. _____ Interviews with the MA on 08/22/24 at 8:26am and 5:01pm revealed: -She had not documented the morning [8:00am] medication administration on the medication administration record (MAR) for any of the residents. -She was going to clean up and then document on the MAR. -She knew she was supposed to document on the MAR right after she gave [administered] the residents their medications. -She called the residents one at a time to the medication room and administered their medications. -She administered the residents their medications correctly on 08/21/24 and 08/22/24; she thought she had documented on the MAR the day before,	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 341	Continued From page 15 08/21/24. Interview with the Administrator on 08/22/24 at 12:45pm revealed: -The MA was supposed to use the MAR and compare the medication to the orders on the MAR and then pull the medications. -The MA individually administered the residents' medications and documented their initials on the MAR after each resident. -The MA should not administer medication to the next resident until they have initialed on the MAR. -It did not matter if the MA was pressed for time; the right way was to administer, and document medication administration was one resident at a time.	C 341		