STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL035035	A. BUILDING: _____ B. WING _____	R 11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DIVINE FAMILY CARE HOME III AT MASON ST	108 EAST MASON ST FRANKLINTON, NC 27525

(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 November 6, 2024.	C 000		
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 orders for 1 of 3 sampled residents (#3) including medications for anxiety, sleep and behaviors. The findings are: Review of Resident #3's current FL-2 dated 08/29/24 revealed diagnoses included major depression, dementia, heart disease, diabetes mellitus type 2, history of fractured femur, and gastro-esophageal reflux disease (GERD). 1. Review of Resident #3's current FL-2 dated 08/29/24 revealed there was an order for quetiapine 25mg (used to treat behaviors or	C 315	Measure put in place to correct the deficient area of practice was the Medication Aide faxed a copy of the current order to the FCH pharmacy. The physician order signed was updated to reflect the new order from the provider.	11/11/2024

Reviewed and acknowledged 11/25/24 Janet Thornburg

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C 315	Continued From page 1 mood disorder) at bedtime. Review of Resident #3's signed physician orders dated 09/16/24 revealed there was an order to change quetiapine 25mg to twice daily. Review of Resident #3's signed physician orders dated 10/01/24 revealed there was an order for quetiapine 25mg daily. Review of Resident #3's September 2024 medication administration record (MAR) revealed: -There was an entry for quetiapine 25mg daily with a scheduled administration time of 9:00pm. -There was documentation quetiapine was administered nightly from 09/01/24 to 09/30/24. Review of Resident #3's October 2024 MAR revealed: -There was an entry for quetiapine 25mg daily with a scheduled administration time of 9:00pm. -There was documentation quetiapine was administered nightly from 10/01/24 to 10/31/24. Review of Resident #3's November 2024 MAR from 11/01/24 to 11/05/24 revealed: -There was a computerized entry for quetiapine 25mg daily with a scheduled administration time of 9:00pm. -There was a handwritten entry to discontinue quetiapine 25mg daily. -There was a handwritten entry for quetiapine 25mg twice daily with a scheduled administration time of 8:00am and 9:00pm. -There was documentation quetiapine was administered twice daily from 11/01/24 to 11/05/24. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/06/24 at	C 315	Measure put in place to correct the deficient area of practice was the Medication Aide faxed a copy of the current order to the FCH pharmacy. The physician order signed was updated to reflect the new order from the provider. To address the identified issue, Divine Family Care Home III at Mason Street has implemented a corrective measure. Going forward, a copy of the updated physician's order for each resident will be faxed to the FCH Pharmacy by the Medication Aide on duty within 24 hours of the new order being issued by the provider. The new orders are updated on the Physician Order Forms the same day by the Medication Aide on duty. Additionally, the Registered Nurse at Divine Family Care Home will acknowledge receipt of the new order and retain a copy for their records. Registered Nurse will follow up with Medication Aide on duty to ensure orders that are signed by the provider reflect the latest orders and written on the MAR. Medication Aide New Order Follow-Up Procedure: 1. Review of New Orders: The Medication Aide is responsible for reviewing all new medication orders promptly after they are issued within 24 hours. 2. Update and Notification: If a new medication order is written after the provider has already reviewed and signed the resident's orders for the current month, the following steps will be taken: - The Medication Aide will notify the provider during the monthly visit with resident. If monthly provider visit has passed the Registered Nurse will notify the provider of the new order. The Registered Nurse will follow up monthly with the care home by reviewing monthly orders auditing. The auditing will be decreased to quarterly after three monthly audits of no deficits. - This notification will be sent via email or fax and will request the provider's acknowledgment, review, and signature on the updated order. 3. Documentation: - A copy of the new medication order, along with the provider's signed acknowledgment, will be placed in the resident's file to ensure proper documentation and compliance. Registered Nurse will retain a copy of order as well.	11/11/2024 11/11/2024 11/11/2024 11/11/2024 11/11/2024 11/11/2024

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C 315	Continued From page 2 11:20am revealed: -The pharmacy received a visit summary note from Resident #3's Mental Health Provider (MHP) on 09/16/24. -In the visit summary note there was documentation to change quetiapine 25mg twice daily. -The pharmacy did not receive an order for the quetiapine with the visit summary note. -The pharmacy sent a request for an order for quetiapine 25mg to be changed to twice daily as was noted in the visit summary note 09/16/24. -The pharmacy received the order to change quetiapine to 25mg twice daily on 09/30/24. -Quetiapine was used for mood and behavior. Interview with the medication aide (MA) on 11/06/24 at 11:41am revealed she handwrote the order for quetiapine to 25mg twice daily on the October 2024 MAR but failed to write the change on the physician orders that were signed by the MHP on 10/01/24. Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/06/24 at 11:20am. Refer to the interview with the medication aide (MA) on 11/06/24 at 11:41am. Refer to the telephone interview with the Administrator on 11/06/24 at 12:30pm. 2. Review of Resident #3's signed physician orders dated 09/16/24 revealed there was an order for trazodone 50mg (used for sleep) ½ tablet at bedtime. Review of Resident #3's signed physician orders dated 10/01/24 revealed there was no order for	C 315	4. Timeliness: All notifications and updates will be completed in a timely manner to ensure that resident care is not delayed or disrupted. The frequency of monitoring and auditing to ensure the current orders are signed and reflect the MAR is performed every month by the Medication Aide and Registered Nurse. The auditing will be decreased to quarterly after three audits without deficits.	11/11/2024

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C 315	Continued From page 3 trazodone 50mg ½ tablet at bedtime. Review of Resident #3's September 2024 medication administration record (MAR) from 09/16/24 to 09/30/24 revealed: -There was no entry for trazodone 50mg ½ tablet at bedtime. -There was no documentation trazodone was administered from 09/16/24 to 09/30/24. Review of Resident #3's October 2024 MAR from revealed: -There was a handwritten entry for trazodone 50mg ½ tablet at bedtime. -There was documentation that trazodone was administered nightly from 10/01/24 to 10/30/24. Review of Resident #3's November 2024 MAR from 11/01/24 to 11/05/24 revealed: -There was an entry for trazodone 50mg ½ tablet at bedtime. -There was documentation that trazodone was administered nightly from 11/01/24 to 11/05/24. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/06/24 at 11:20am revealed: -The pharmacy received a visit summary note from Resident #3's Mental Health Provider (MHP) on 09/16/24. -In the visit summary note there was documentation to add trazodone 50mg ½ tablet at bedtime for sleep. -The pharmacy did not receive an order for the trazodone 50mg ½ tablet at bedtime with the visit summary note. -The pharmacy sent a request for an order for trazodone 50mg ½ tablet at bedtime as was noted in the visit summary note dated 09/16/24. -The pharmacy received the order for trazodone	C 315		

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C 315	Continued From page 4 50mg ½ tablet at bedtime on 09/30/24. -Trazodone was used for insomnia. Interview with the medication aide (MA) on 11/06/24 at 11:41am revealed she handwrote the order for trazodone 50mg ½ tablet at bedtime on the October 2024 MAR but failed to write the change on the physician orders that were signed by the MHP on 10/01/24. Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/06/24 at 11:20am. Refer to the interview with the medication aide (MA) on 11/06/24 at 11:41am. Refer to the telephone interview with the Administrator on 11/06/24 at 12:30pm. 3. Review of Resident #3's signed physician orders dated 09/16/24 revealed there was an order for lorazepam 0.5mg (used to treat anxiety) ½ tablet twice daily as needed (PRN). Review of Resident #3's signed physician orders dated 10/01/24 revealed there was no Order for lorazepam 0.5mg ½ tablet twice daily PRN. Review of Resident #3's September 2024 medication administration record (MAR) from 09/16/24 to 09/30/24 revealed: -There was no entry for lorazepam 0.5mg ½ tablet twice daily PRN. -There was no documentation that lorazepam was administered in September 2024. Review of Resident #3's October 2024 medication administration record (MAR) revealed:	C 315		

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C 315	Continued From page 5 -There was a handwritten entry for lorazepam 0.5mg ½ tablet twice daily PRN. -There was documentation that lorazepam was administered 14 times from 10/01/24 to 10/30/24. Review of Resident #3's November 2024 MAR from 11/01/24 to 11/05/24 revealed: -There was an entry for lorazepam 0.5mg ½ tablet twice daily PRN. -There was no documentation that lorazepam was administered from 11/01/24 to 11/05/24. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/06/24 at 11:20am revealed: -The pharmacy received a visit summary note from Resident #3's Mental Health Provider (MHP) on 09/16/24. -In the visit summary note there was documentation to add lorazepam 0.5mg ½ tablet twice daily PRN -The pharmacy did not receive an order for the lorazepam 0.5mg ½ tablet twice daily PRN with the visit summary note. -The pharmacy sent a request for an order for lorazepam 0.5mg ½ tablet twice daily PRN as was noted in the visit summary note dated 09/16/24. -The pharmacy received the order for lorazepam 0.5mg ½ tablet twice daily PRN on 09/30/24. -Lorazepam was used for anxiety and agitation. Interview with the medication aide (MA) on 11/06/24 at 11:41am revealed she handwrote the order for lorazepam 0.5mg ½ tablet twice daily on the October 2024 MAR but failed to write the change on the physician orders that were signed by the MHP on 10/01/24.	C 315		

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C 315	Continued From page 6 Refer to the telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/06/24 at 11:20am. Refer to the interview with the medication aide (MA) on 11/06/24 at 11:41am. Refer to the telephone interview with the Administrator on 11/06/24 at 12:30pm. _____ Telephone interview with the Pharmacist at the facility's contracted pharmacy on 11/06/24 at 11:20am revealed: -The medication administration records (MARS) and a copy of the physician orders were sent to the facility the last week of the month. -The facility staff was responsible for making changes to the MARS and physician orders for any new orders that were written after the physician orders and MARS had been printed and sent to the facility. -The pharmacy did not receive a copy of the signed physician order dated 10/01/24. -The pharmacy would have reviewed the physician orders for clarification to ensure that all orders were on the most recently signed physician orders. Interview with the medication aide (MA) on 11/06/24 at 11:41am revealed: -The MARs and physician orders arrived at the facility the last week of the month. -She would review the MARs and physician orders that were in the resident's record. -She would handwrite any new orders that were written by the MHP the last week of the month to the upcoming months MAR. -She failed to ensure that the new orders written on the MARs were also changed on the physician's order before the MHP signed them on	C 315		

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C 315	Continued From page 7 10/01/24. Telephone interview with the Administrator on 11/06/24 at 12:30pm revealed: -He expected the MAs to review all orders and update the printed MARs received by the pharmacy the last week of the month. -The MA should review and ensure the orders are accurate at the beginning of each month.	C 315		