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
	FCL098032	A. BUILDING _____ B. WING _____	R 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLED 2 CARE FAMILY CARE HOME # 2	502 POE STREET WILSON, NC 27893

(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 May 20, 2025 and May 21, 2025	C 000	Administrator will ensure the Resident's that have wandering tendencies will not be admitted and that will be decided on the initial assessment day. Reminder notes are posted in administrative office POC corrected on 5/27/25	
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors accessible to residents who were assessed to be disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Review of the facility's current license effective	C 069	Resident #3 no longer wanders has an updated FL-2 dated 5/27/25 The home no longer admits residents that wanders and that is determined in the in assessments	5/27/25

Received via email 07/03/25.
Reviewed and Acknowledged 07/08/25. Watts RN

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 069	Continued From page 1 01/01/25 revealed the facility was licensed as a family care home with a capacity of 6 ambulatory residents. Initial observation of the front entrance/exit door upon arrival at the facility on 05/20/25 at 8:45am revealed: -The door was unlocked. -There was no audible sound heard when the door was opened. Observation of 3 of 3 facility exit doors during the initial tour of the facility from 8:00am to 9:57am revealed there were no audible sounding device heard when the exit doors were opened. Interview with the Administrator on 05/20/25 at 9:57am revealed: -There were no alarms on the facility exit doors. -She used to have alarms on the exit doors. -The alarms were removed because she did not have wandering residents at the facility. Review of Resident #3's current FL-2 dated 10/22/24 revealed there was a checkmark documented next to Intermittently in the section of patient information for disorientation. Review of Resident #3's assessment and care plan dated 10/22/24 revealed: -On 10/21/24, the Administrator assessed Resident #3 to be sometimes disoriented. -On 10/22/24, there was a signature for the Primary Care Provider. -Resident #3 was ambulatory. Interview with the medication aide (MA) on 05/20/25 at 1:08pm revealed: -Resident #3 did not walk away from the facility. -Resident #3 would go for a walk every day and	C 069	5/21/25 Updated FL-2 5-27-25	

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C 069	Continued From page 2 return to the facility -Resident #3 did not wander. -The Administrator completed information on the FL-2. Interview with the Administrator on 05/21/25 at 12:10pm revealed: -She was responsible for completing the FL-2 prior to submitting for the primary care provider review and signature. -Resident #3 was not a wanderer. -Resident #3 would forget certain things like when the resident talked to family members. -It was like you had to prompt Resident #3 to remember. Interview with the Primary Care Provider was unsuccessful on 05/21/25 at 9:14am.	C 069		5/27/25
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#2) were tested upon admission for tuberculosis	C 202		

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C 202 Continued From page 3

TB) disease in compliance with the control measures by the Commission for Public Health

The findings are

Review of Resident #2's current FL 2 dated 12/13/24 revealed diagnoses included major depression disorder, seizures, and traumatic brain injury.

Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 01/16/25 from another facility.

Review of Resident #2's record on 05/20/25 revealed:
-There was documentation for a tuberculosis (TB) skin test given on 12/13/24 and read as 0mm negative on 12/16/24.
-There were no additional TB test results available for review.

Interview with the Administrator on 05/20/25 at 12:35pm revealed:
-There had not been a TB skin test completed for Resident #2 since the resident was admitted to the facility.
-She thought Resident #2 was admitted directly from another facility.
-She (Administrator) did not know the resident needed another TB skin test.

Telephone interview with Resident#2's guardian on 05/20/25 at 3:25pm revealed:
-Resident #2 was discharged from another facility around the end of December 2024 (no date provided).
-The resident went home to live with family after being discharged from another facility until placement was found at the current facility.

C 202

Resident #2, and TB screening 5/21/25 given 5/21/25 5/21/25 read @ Wilson Co Health Department

Corrected on 5/21/25 Administrator will double check with the admitting facility to ensure if a TB skin test has been completed before admission

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C 202	Continued From page 4 -She requested the TB skin test be completed prior to discharge because she knew Resident #2 would need a TB skin test prior to admission to another facility.	C 202		
C 203	10A NCAC 13G 0702 (b) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test And Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the home and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the FL-2 for 1 of 3 sampled residents (#1) was updated annually. The findings are: Review of Resident #1's record on 05/20/25 revealed: -There was an FL-2 dated 09/19/23 with diagnoses of schizophrenia, hypertension, chronic kidney disease, and benign prostatic	C 203		

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C 203	Continued From page 5 hypertrophy There was a second FL-2 form with information completed in the sections for identification, patient information and medications -There was no physician signature or date on the second FL-2 -There was no physician signed FL-2 completed since the 09 19/23 FL-2 Review of Resident #1's Resident Register revealed an admission date of 10/06/17 Interview with the Administrator on 05/20/25 at 1 45pm revealed -There was supposed to be an FL-2 for Resident #1 completed in 2024 -The LHPS nurse noted there was an FL-2 date of 10'22'24 on the LHPS review for Resident #1. -The year of 2023 documented on the signed FL-2 was supposed to be 2024. Interview with the Administrator on 05/21/25 at 10 36am revealed -Resident #1's FL-2 needed to be signed. -She completed the unsigned FL-2 in Resident #1's record and faxed it to the primary care provider (PCP) office for signature but had not received the signed FL-2 yet. -It was hard to get paperwork completed by Resident #1's PCP. -She did not have any documentation to verify when she sent the FL-2 to the PCP for signature. -Resident #1 was only seen by the primary care provider yearly. Second interview with the Administrator on 05/21/25 at 12:55pm revealed: -She had been working more than normal. -She was responsible for ensuring information in residents records was accurate.	C 203	resident #1 had all forms completed on Correct on 5/23/25 signed by Dr. 5/23/25 Administrator will make sure to do *quarterly checks on all charts to ensure that all forms are updated properly. All forms were mailed to the facility and placed in resident chart. Quarterly checks done on all charts to ensure updated forms.	

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C 203	Continued From page 6 -She did not have a record review process in place	C 203		
C 240	10A NCAC 13G .0802(e) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure the residents' physician signed and dated the care plan within 15 days of the assessment for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's FL-2 dated 09/19/23 revealed: -The residents' diagnoses included schizophrenia, hypertension, chronic kidney disease, and benign prostatic hypertrophy. -The resident was documented as ambulatory. -There was no documentation regarding personal care assistance needed. Review of an unsigned and undated FL-2 form in the record for Resident #1 FL-2 revealed: -There were no diagnoses listed. -The resident was documented as ambulatory.	C 240	5/22/25	

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C 240	Continued From page 7 -The resident was incontinent of bladder. -The resident required "limited" assistance with bathing. Review of Resident #1's Resident Register revealed an admission of 10/06/17. Review of Resident #1's assessment and care plans on 05/21/25 revealed: -There was a completed assessment and care plan dated 09/18/23. -The assessor completed and dated a second assessment and care plan on 10/22/24. -The resident was documented as sometimes disoriented. -The assessment and care plan completed by the assessor and dated 10/22/24 was not signed and dated by the primary care provider (PCP). Interview with the Administrator on 05/21/25 at 10:36am revealed: -Resident #1's care plan and assessment needed to be signed. -She completed the assessment on Resident #1 and faxed it to the primary care provider (PCP) office for signature but had not received the signed care plan and assessment yet. -It was hard to get paperwork completed by Resident #1's PCP. -She did not have any documentation to verify when she sent the care plan and assessment to the PCP for signature. Second interview with the Administrator on 05/21/25 at 12:55pm revealed: -She had been working more than normal. -She was responsible for ensuring information in residents records was accurate. -She did not have a record review process in place.	C 240		5/22/25

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C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the implementation of physician's orders for 1 of 3 sampled residents (#3) with orders for fingerstick blood sugar checks twice a day. The findings are: Review of Resident #3's current FL2 dated 10/22/24 revealed: -Diagnoses included diabetes, Parkinson's disease, hypertension, dyspnea, and vitamin D deficiency. -There was a physician's order to for fingerstick blood sugar (FSBS) checks twice a day before breakfast and supper. Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 11/16/19. Review of 04/2025 and 05/2025 medication administration records (MARs) revealed: -There were no entries printed to the MARs for FSBS checks twice a day. -There were no documented FSBS results on the	C 249	Corrected on 5-26-25 Resident #3 Has received a new glucometer that has been labeled with her name on it only for her use. on May 28th 5/28/25	

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C 249	Continued from page 9 MARs Review of documentation of a fingerstick blood sugar (FSBS) flow sheet results for Resident #3 revealed There were FSBS results for 03/03/25, 03/12/25, 03/15/25-03/26/25, and 03/31/25 with documented FSBS's twice daily and ranging from 98 to 202 -There was a handwritten entry at the top of the FSBS flow sheet which read "take and record blood sugar before breakfast supper" -There were no additional FSBS flow sheets available for review Review of a licensed health professional support review and evaluation dated 04/23/25 revealed: -There was an entry for "FSBS - 8am/5pm - check record daily". -There was a recommendation to "continue POC (plan of care)". Interview with the medication aide (MA) on 05/20/25 at 9:30am revealed: -Resident #3 was the only diabetic resident at the facility. -The resident's FSBS was checked twice a day, before breakfast and supper. -The resident's FSBS was not documented but used to be documented. -The facility used a blood sugar flow sheet for documenting FSBS results. Interview with the Administrator on 05/20/25 at 9:34am revealed she did not know the FSBS results for Resident #3 were not being documented. Interview with the Administrator on 05/21/25 at 10:07am revealed	C 249	Corrected on 5-21-25 * Administrator had staff meeting to inquire everyone not to use fingers meter sticks the meters are for use not for multiple use. Also to ensure appropriate charting of FSBS. Make sure that we chart properly in the chart after sometimes recording it on paper but transfer to the charts promptly. Weekly checks will be done to ensure proper documentation	5/21/25

C 249	Continued From page 10	C 249

The MAs had not been documenting FSBS results for Resident #3
-The resident's FSBS was never over 200
-At one time, the MAs were documenting FSBS results for Resident #3
-She checked Resident #3's FSBS whenever she worked at the facility.
-She would document the resident's FSBS on a piece of paper and if she got busy she would forget to document the FSBS result for Resident #3 on the FSBS flow sheet
-Resident #3's FSBS was checked two times a day
-She was not able to show that the resident's FSBSs were checked

Telephone interview with Resident #3's Primary Care Physician's (PCP) Nurse on 05/21/25 at 9 14am revealed.
-Resident #3 was diabetic
-Resident #3's FSBS was supposed to be checked twice a day
-The resident's FSBS results should be documented on the so the PCP can review them when the resident was seen
-The facility was supposed to bring the residents' MAR to each PCP visit

Telephone interview with the Primary Care Provider was unsuccessful on 05/21/25 at 9:14am

Interview with Resident #3 on 05/21/25 at 1 52pm revealed:
-The MAs checked her FSBS in the morning and in the evening before meals.
-The MAs wrote the FSBS results on a piece of paper.
-The Administrator checked the residents' FSBS when the Administrator worked

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C 249	(Continued from page 11)	C 249		

The residents FSBS results were usually 140 to 150.
When the residents FSBS was over 200 she was administered insulin

C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration 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, record reviews, and interviews, the facility failed to ensure accurate documentation for the administration of medications on the medication administration records (MARs) residents including 3 of 3 sampled residents (#1, #2, #3).	C 342	Administrator will ensure that documentation is done correctly. Will Check Staff meeting will done to address the issue. POC corrected on 5-31-25 MARs will accurately be documented during each shift Administrator will oversee that is done	5/31/25

CALLED 2 CARE FAMILY CARE HOME # 2

502 POE STREET
WILSON, NC 27893

C 342	Continued From page 12	C 342

The findings are

1 Review of Resident #1 s FL-2 dated 09/19/23 revealed diagnoses included schizophrenia hypertension, chronic kidney disease and benign prostatic hypertrophy

a Review of Resident #1's physician's orders dated 05/21/24 revealed there was an order for ferrous sulfate (used to treat anemia) 324mg tablet daily on an empty stomach

Review of Resident #1's May 2025 medication administration records (MARs) on 05/20/25 at 11 09am revealed:
-There was a handwritten entry for ferrous sulfate mg tablet daily and scheduled at 8 00am
-There was no documentation of administration for the scheduled 8 00am dose on 05/09/25-05/11/25 and 05/16/25
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the ferrous sulfate

Observation of medications on hand for Resident #1 on 05/21/25 revealed ferrous sulfate 324mg tablets were on hand. The ferrous sulfate was dispensed on 04/01/25, available for administration but not documented as administered.

b. Review of Resident #1's physician's orders dated 05/21/24 revealed there was an order for risperidone (used to treat behaviors) 2mg tablet at bedtime and ½ tablet every morning

Review of Resident #1's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed:
-There was a handwritten entry for risperidone

C 342	Continued From page 13 2nd tablet at bedtime and scheduled at 8 00pm There was no documentation of administration to the scheduled 8 00pm dose on 05 01 25 05/02 25 05/09 25-05/11/25 05/15/25 and 05/16/25 There was a handwritten entry for risperidone 2mg tablet take ½ tablet every morning and scheduled at 8 00am -There was no documentation of administration for the scheduled 8 00am dose on 05/09/25-05/11/25. and 05/16/25 -There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the risperidone Observation of medications on hand for Resident #1 on 05/21/25 revealed risperidone 2mg tablets were on hand The risperidone was dispensed on 04/09/25, available for administration but not documented as administered c Review of Resident #1's physician's orders dated 05/21/24 revealed there was an order for cholecalciferol (dietary supplement) 25mcg take two tablets once daily Review of Resident #1's May 2025 medication administration records (MARs) on 05/20/25 at 11 09am revealed -There was a handwritten entry for cholecalciferol 25mcg take two tablets daily and scheduled at 8 00am -There was no documentation of administration for the scheduled 8 00am dose on 05/09/25-05/11/25. and 05/16/25 -There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the cholecalciferol Observation of medications on hand for Resident	C 342	

C 342 Continued From page 14	C 342

#1 on 05/21/25 revealed cholecalciferol 25mcg tablets were on hand. The cholecalciferol was dispensed on 04/01/25, available for administration but not documented as administered

Interview with Resident #1 on 05/20/25 at 8:44am revealed
-He was administered medications by staff at the facility
-He could not provide the names of his medications

Refer to the interview with the Administrator dated 05/20/25 at 1:30pm

2. Review of Resident #2's FL-2 dated 12/13/24 revealed diagnoses included major depression disorder, traumatic brain injury, and seizures.

a. Review of Resident #2's physician's orders dated 12/13/24 revealed there was an order for levetiracetam (generic for Keppra and used to treat seizures) 1000mg tablet twice daily

Review of Resident #2's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed
-There was a printed entry for levetiracetam 1000 mg tablet twice daily and scheduled at 8:00am and 8:00pm
-There was no documentation of administration for the scheduled 8:00am and 8:00pm doses on 05/11/25.
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the levetiracetam

Observation of medications on hand for Resident #2 on 05/21/25 revealed levetiracetam 1000mg

C 342 Continued From page 15

C 342

tablets were on hand The levetiracetam was dispensed on 05/02/25, available for administration but not documented as administered

b Review of Resident #2's physician's orders dated 12/13/24 revealed there was an order for sertraline (generic for zoloft and used to treat behavior) 100mg tablet once daily

Review of Resident #2's May 2025 medication administration records (MARs) on 05/20/25 at 11 09am revealed
-There was a printed entry for sertraline 100mg tablet once daily and scheduled at 8 00pm
-There was no documentation of administration for the scheduled 8 00pm dose on 05/11/25
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the sertraline

Observation of medications on hand for Resident #2 on 05/21/25 revealed sertraline 100mg tablets were on hand The sertraline was dispensed on 05/08/25, available for administration but not documented as administered.

c Review of Resident #2's physician's orders dated 12/13/24 revealed there was an order for topiramate (generic for topamax and used to treat seizures) 100mg tablet twice daily

Review of Resident #2's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed.
-There was a printed entry for topiramate 100mg tablet twice daily and scheduled at 8.00am and 8:00pm
-There was no documentation of administration for the scheduled 8:00am and 8.00pm doses on

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
C 342	Continued From page 16 05/11/25 -There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the topiramate Observation of medications on hand for Resident #2 on 05/21/25 revealed topiramate100mg tablets were on hand The topiramate was dispensed on 04/16/25, available for administration but not documented as administered. d Review of Resident #2's physician's orders dated 12/13/24 revealed there was an order for vitamin D3 (generic for vimpat and used to treat seizures) 200mg tablet twice daily. Review of Resident #2's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed: -There was a printed entry for lacosamide 200mg tablet twice daily and scheduled at 8.00am and 8:00pm -There was no documentation of administration for the scheduled 8.00pm dose on 05/11/25 -There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the lacosamide Observation of medications on hand for Resident #2 on 05/21/25 revealed lacosamide 200mg tablets were on hand The lacosamide was dispensed on 04/14/25, available for administration but not documented as administered. Interview with Resident #2 on 05/20/25 at 8 15am revealed: -She had not missed any administration of medication. -Staff at the facility administered her medications	C 342	

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C 342	C 342	

Continued From page 17

She was prescribed three medications for seizures

Refer to the interview with the Administrator dated 05/20/25 at 1 30pm

3 Review of Resident #3's FL-2 dated 10/22/24 revealed diagnoses included diabetes mellitus, Parkinson's disease, hypertension, and vitamin D deficiency

a Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for norvasc (used to treat high blood pressure) 10mg tablet daily

Review of a subsequent physician's order dated 05/19/25 revealed an order to discontinue the Norvasc

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11 09am revealed
-There was a printed entry for amlodipine (generic for norvasc) 10mg tablet daily and scheduled at 8.00am
-There was no documentation of administration for the scheduled 8 00am dose on 05/02/25, 05/09/25-05/11/25, and 05/16/25
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the norvasc

Observation of medications on hand for Resident #3 on 05/20/25 revealed there was no norvasc 10mg tablets on hand.

b Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for losartan potassium (used to treat high blood

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pressure) 50mg tablet daily

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed
-There was a printed entry for losartan potassium 50mg tablet daily and scheduled at 8:00am
-There was no documentation of administration for the scheduled 8:00am dose on 05/02/25, 05/09/25-05/11/25, and 05/16/25
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the losartan potassium.

Observation of medications on hand for Resident #3 on 05/20/25 revealed losartan potassium 50mg tablets were on hand. The losartan potassium was dispensed on 03/27/25, available for administration but not documented as administered.

c. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for lipitor (used to treat high cholesterol) 20mg tablet daily.

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed:
-There was a printed entry for Lipitor 20mg tablet daily and scheduled at 8:00pm.
-There was no documentation of administration for the scheduled 8:00pm dose on 05/01/25-05/04/25, 05/08/25-05/11/25, 05/15/25, and 05/16/25.
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the losartan potassium.

Observation of medications on hand for Resident

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C 342

#3 on 05/20/25 revealed Lipitor 20mg tablets were on hand. The lipitor was dispensed on 03/27/25 available for administration but not documented as administered.

d. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for metformin (used to diabetes mellitus) 500mg take two tablets every morning and two tablets every evening.

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed:
-There was a printed entry for metformin 500mg take two tablets every morning and scheduled at 8:00am.
-There was no documentation of administration for the scheduled 8:00am dose on 05/02/25, 05/09/25-05/11/25, and 05/16/25.
-There was a printed entry for metformin 500mg take two tablets every evening and scheduled at 8:00pm.
-There was no documentation of administration for the scheduled 8:00pm dose on 05/01/25-05/04/25, 05/08/25-05/11/25, 05/15/25, and 05/16/25.
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the metformin.

Observation of medications on hand for Resident #3 on 05/20/25 revealed metformin 500mg tablets were on hand. The metformin was dispensed on 03/27/25, available for administration but not documented as administered.

e. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for

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C 342	Continued From page 20 pantoprazole (used to treat heartburn and stomach digestive disorders) 40mg tablet daily Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed: -There was a printed entry for pantoprazole 40mg tablet daily and scheduled at 6:30am. -There was no documentation of administration for the scheduled 6:30am dose on 05/02/25, 05/09/25-05/11/25, and 05/16/25. -There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the pantoprazole. Observation of medications on hand for Resident #3 on 05/20/25 revealed pantoprazole 40mg tablets were on hand. The pantoprazole was dispensed on 03/27/25, available for administration but not documented as administered. f. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for olanzapine (used to treat behaviors) 7.5mg tablet daily. Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed: -There was a printed entry for olanzapine 7.5mg tablet daily and scheduled at 8:00pm. -There was no documentation of administration for the scheduled 8:00pm dose on 05/01/25-05/04/25, 05/08/25-05/11/25, 05/15/25, and 05/16/25. -There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the olanzapine.	C 342		

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Observation of medications on hand for Resident #3 on 05/20/25 revealed olanzapine 7.5mg tablets were on hand. The olanzapine was dispensed on 04/28/25, available for administration but not documented as administered.

g. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for montelukast (used to treat allergies) 10mg tablet daily.

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed
-There was a handwritten entry for montelukast 10mg tablet at bedtime and scheduled at 8:00pm.
-There was no documentation of administration for the scheduled 8:00pm dose on 05/01/25-05/02/25, 05/08/25-05/11/25, 05/15/25, and 05/16/25.
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the montelukast.

Observation of medications on hand for Resident #3 on 05/20/25 revealed montelukast 10mg tablets were on hand. The montelukast was dispensed on 04/28/25, available for administration but not documented as administered.

h. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for trusopt solution 2% (used to treat glaucoma) ophthalmic instill one drop in both eyes twice daily.

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at

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11:09am revealed
There was a printed entry for dorzolamide solution 2% ophthalmic (generic for trusopt) instill one drop in both eyes twice daily and scheduled at 8:00am and 8:00pm
-There was no documentation of administration for the scheduled 8:00pm dose for 05/01/25 through 05/19/25 and the 8:00am dose on 05/02/25 05/09/25-05/11/25 and 05/16/25
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the trusopt eye drops

Observation of medications on hand for Resident #3 on 05/20/25 revealed the trusopt eye drops were on hand The trusopt eye drops were dispensed on 04/28/25, available for administration but not documented as administered.

i. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for latanoprost solution 0.005% (used to treat glaucoma) ophthalmic instill one drop in both eyes twice daily.

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed:
-There was a printed entry for latanoprost solution 0.005% ophthalmic (generic for xalatan) instill one drop in both eyes once daily and scheduled at 8:00pm.
-There was no documentation of administration for the scheduled 8:00pm dose for 05/01/25-05/02/25, 05/08/25-05/11/25, and 05/16/25.
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the latanoprost eye drops.

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Observation of medications on hand for Resident #3 on 05/20/25 revealed the latanoprost eye drops were on hand. The latanoprost eye drops were dispensed on 04/24/25, available for administration but not documented as administered.

j. Review of Resident #3's physician's orders dated 10/22/24 revealed there was an order for timolol maleate solution 0.5% (used to treat glaucoma) ophthalmic instill one drop in both eyes twice daily.

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed:
-There was a printed entry for timolol maleate solution 0.5% ophthalmic (generic for timoptic) instill one drop in both eyes twice daily and scheduled at 8:00am and 8:00pm.
-There was no documentation of administration for the scheduled 8:00am dose for 05/02/25, 05/09/25-05/11/25, and 05/16/25.
-There was no documentation of administration for the scheduled 8:00pm dose for 05/01/25-05/04/25, 05/08/25-05/11/25, 05/15/25, and 05/16/25.
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the timolol eye drops.

Observation of medications on hand for Resident #3 on 05/20/25 revealed the latanoprost eye drops were on hand. The timolol eye drops were dispensed on 02/24/25, available for administration but not documented as administered.

k. Review of Resident #3's physician's orders

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dated 10/22/24 revealed there was an order for trelegy ellipta 200-62 5-25 (used to treat breathing disorders) inhale one puff daily

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed
-There was a handwritten entry for trelegy ellipta to inhale one puff once daily and scheduled at 8:00am
-There was no documentation of administration for the scheduled 8:00am dose on 05/02/25, 05/09/25-05/11/25, and 05/16/25.
-There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the trelegy ellipta inhaler.

Observation of medications on hand for Resident #3 on 05/20/25 revealed the trelegy ellipta inhaler powder was on hand. The inhaler powder was dispensed on 04/28/25, available for administration but not documented as administered.

I. Review of a physician's order for Resident #3 dated 05/06/25 revealed there was an order for amoxicillin (used to treat infection) 500mg capsule three times daily until gone.

Review of Resident #3's May 2025 medication administration records (MARs) on 05/20/25 at 11:09am revealed:
-There was a handwritten entry for amoxicillin 500mg capsule three times a day until gone and scheduled at 8:00am, 12:00pm, and 8:00pm, beginning at 8:00am on 05/07/25.
-There was no documentation of administration for the scheduled 8:00am dose on 05/09/25-05/11/25.
-There was no documentation of administration

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C 342	Continued From page 25 for the scheduled 12:00pm and 8:00pm doses on 05/08/25-05/11/25. There was no documentation on the MARs that provided a reason for the lack of documentation of administration for the amoxicillin. Review of a pharmacy dispensing history for Resident #3 revealed amoxicillin 500mg capsules, quantity of 21 were dispensed on 05/06/25. Observation of medications on hand for Resident #3 on 05/20/25 revealed there were no amoxicillin 500mg capsules on hand for the resident. Interview with Resident #3 on 05/21/25 at 1:52pm revealed she was administered medications every day in the morning and at night. Refer to the interview with the Administrator dated 05/20/25 at 1:30pm. --- Interview with the Administrator on 05/20/25 at 1:30pm revealed: -She was responsible for the missing documentation of medication administration on the medication administration records for the residents. -She knew the residents and the medications the residents were prescribed. -She did not always document the administration of medication right after she administered the medications. -She forgot to go back and document the administration of medication for the residents because she had a lot to do sometimes when she worked at the facility.	C 342	

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	10A NCAC 13G .1204 (b) Infection Prevention & Control Policies & Pro	(X4)

10A NCAC 13G .1204 INFECTION PREVENTION AND CONTROL POLICIES & PROCEDURES

(b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following

(1) Standard and transmission based precautions, including

(A) respiratory hygiene and cough etiquette

(B) environmental cleaning and disinfection

(C) reprocessing and disinfection of reusable resident medical equipment

(D) hand hygiene.

(E) accessibility and proper use of personal protective equipment (PPE), and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions,

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1702 of this Section;

(3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and

5 DAYS
25

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C 611	Continued From page 27 (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak This Rule is not met as evidenced by TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to implement a written policy and infection control procedures consistent with the Federal Center for Disease Control and Prevention (CDC) guidelines to ensure proper use of a glucometer for 1 of 1 sampled diabetic resident (#3) with orders for blood sugar monitoring. The findings are: Review of the Center for Disease Control and Prevention (CDC) guidelines for infection control revealed: -There were recommendations that blood glucose monitoring devices (glucometers) should not be shared. -The glucometer should be cleaned and disinfected per the manufacturer's instructions, and 70% ethanol solutions are not effective against viral bloodborne pathogens. -If the manufacturer does not list disinfection information, the glucometer should not be shared. Review of the manufacturer's manual for a blood glucose meter prescribed for single person use revealed: -The meter should never be used by more than one person. -Use of the glucometer on multiple persons may lead to transmission of Human Immunodeficiency Virus (HIV), Hepatitis C Virus (HCV), Hepatitis B	C 611	#1 Administrator will do weekly checks on BS logs to ensure that they are completed POC corrected on → 5/25/25 As stated earlier Resident received a new glucometer 5/28/25 with pouch that has her name #3 Staff meeting was held on 5/28/25 to ensure the safety and that the rules be followed concerning not sharing meters	

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Virus (HBV) or other bloodborne pathogens. Cleaning and disinfecting the meter destroys most, but not necessarily all, bloodborne pathogens.

Review of Resident #3's current FL 2 dated 10/22/24 revealed:
-Diagnosis included diabetes mellitus.
-There was a physician's order for fingerstick blood sugar (FSBS) checks twice daily before breakfast and supper.

Observation of Resident #3's glucometer on 05/20/25 at 4:43pm revealed:
-The glucometer was in a black zippered case labeled with Resident #3's first name.
-The glucometer was not labeled with the resident's name.
-The last date and time on the glucometer screen was 05/20/25 at 7:45am.

Review of Resident #3's medication administration records (MARs) for 04/2025 and 05/2025 revealed:
-There was a printed entry for humalog insulin (an injectable medication used to lower high blood sugar levels) per sliding scale and handwritten sliding scale parameters beginning at a blood sugar reading of 201.
-There was no documentation for administration of the Humalog sliding scale insulin.
-There were no documented blood sugar results for review.

Review of the glucometer history in the zippered case labeled for Resident #3 on 05/20/25 revealed the blood sugar readings and dates included the following:
-On 05/01/25, there were blood sugar readings of 308 at 9:08am, 377 at 12:41pm, 298 at 6:30pm,

Picture of glucometer sent to surveyor by email. 5/28/25

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CALLED 2 CARE FAMILY CARE HOME # 2	502 POE STREET WILSON, NC 27893

(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 611	Continued From page 29 and 425 at 9:44pm. -On 05/02/25, there were blood sugar readings of 344 at 4:34am, 190 at 11:11am, and 240 at 2:27pm. -On 05/03/25, there were blood sugar readings of 151 at 8:46am, 147 at 4:31pm, and 221 at 8:31pm. -On 05/04/25, there was a blood sugar reading of 181 at 9:13am. -On 05/05/25, there were blood sugar readings of 234 at 7:40am, 188 at 8:41am, 165 at 4:45pm, 233 at 4:48pm, and 186 at 7:09pm. -On 05/06/25, there were blood sugar readings of 190 at 8:01am, 198 at 8:58am, 234 at 5:21pm, and 173 at 8:32pm. -On 05/07/25, there were blood sugar readings of 189 at 8:26am, 169 at 5:47pm, 201 at 7:20pm, and 167 at 7:24pm. -On 05/08/25, there were blood sugar readings of 154 at 8:02am and 192 at 8:31am. -On 05/09/25, there were blood sugar readings of 117 at 12:35pm, 127 at 5:32pm, and 243 at 9:00pm. -On 05/10/25, there were blood sugar readings of 154 at 8:44am and 175 at 11:04pm. -On 05/11/25, there were blood sugar readings of 151 at 9:17am, 112 at 2:55pm, and 146 at 10:06pm. -On 05/12/25, there were blood sugar readings of 164 at 7:38am, 140 at 8:28am, and 229 at 6:42pm. -On 05/13/25, there were blood sugar readings of 149 at 7:50am, 144 at 8:35am, and 201 at 7:19pm. -On 05/14/25, there were blood sugar readings of 142 at 7:57am, 145 at 8:24am, and 165 at 6:35pm. -On 05/15/25, there were blood sugar readings of 113 at 7:37am and 201 at 10:12pm. -On 05/16/25, there were blood sugar readings of	C 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	FCI 098032	A. BUILDING _____ B. WING _____	P 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLED 2 CARE FAMILY CARE HOME # 2	502 POE STREET WILSON, NC 27893

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)	COMPLETE DATE
C 611	Continued From page 30	C 611		

112 at 9:00am, 79 at 2:43pm, 81 at 2:46pm, and 217 at 5:52pm
-On 05/17/25, there were blood sugar readings of 89 at 12:14pm and 176 at 10:27pm
-On 05/18/25, there were blood sugar readings of 106 at 11:16am and 140 at 8:56pm
-On 05/19/25, there were blood sugar readings of 163 at 7:42am, 170 at 8:07am, 135 at 4:50pm, and 144 at 9:54pm
-On 05/20/25, there was a blood sugar reading of 175 at 7:46am.

Interview with the Administrator on 05/20/25 at 9:30am revealed:
-Resident #3 was the only resident at the facility that was diabetic.
-The residents' blood sugar was checked twice daily before breakfast and supper.
-The residents' blood sugar results were "always good".
-She did not know why the blood sugar results for Resident #3 were not documented.

Interview with the medication aide (MA) on 05/20/25 at 9:31am revealed:
-Resident #3's blood sugars were checked twice daily.
-She did not document the blood sugar results on the blood sugar log that was in the medication administration records book.
-She used to document Resident #3's blood sugar results.

Interview with the Administrator on 05/21/25 at 1:10pm revealed:
-She checked her own blood sugar at the facility with a glucometer from the medication cart if she felt bad when she worked at the facility, and knew staff were "not supposed to do that."
-The glucometer used at the facility was for

5/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL008032	A. BUILDING _____ B. WING _____	R 05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLED 2 CARE FAMILY CARE HOME # 2	602 POE STREET WILSON, NC 27893

(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 611	Continued From page 31 multiple person use -Resident #3's original glucometer broke, and staff started using the facility "house meter." -Alcohol was used to wipe the glucometer when used. Interview with Resident #3 on 05/21/25 at 1:52pm revealed: -Her blood sugar was checked in the morning and evening before she ate a meal. -Her blood sugar reading was usually 140 - 150 and did not get higher than 165. -The glucometer used belonged to the facility. -The glucometer used was "a little black glucometer." -The MAs and the Administrator checked her blood sugar when they worked. Second interview with the Administrator on 05/21/25 between 2:13pm revealed: -She did not have a written policy for medication and infection control. -The MAs were trained in infection control according to state rules and regulations. -She sanitized the glucometer with alcohol after use. Interview with the MA on 05/21/25 at 2:17pm revealed: -She sanitized the glucometer with alcohol. -She wiped the "front, back, side, and little hole with alcohol" after use. Attempted telephone interview with the primary care provider (PCP) on 05/21/25 at 9:00am was unsuccessful. The facility failed to implement infection control procedures consistent with the Center for Disease Control and Prevention (CDC) guidelines	C 611		5/25/25

	FCL090032		

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALLED 2 CARE FAMILY CARE HOME # 2	502 POG STREET WILSON, NC 27893

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)
C 611	Continued From page 32 resulting in a single use glucometer used for multiple persons, placing Resident #3 at risk for bloodborne pathogen diseases This failure was detrimental to the health, safety, and welfare of the resident, and constitutes a Type B Violation The facility provided a plan of protection in accordance with G S 131D-34 on 05/21/25 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 5, 2025	C 611	

5/23/25

Forte, Hope

From: Mary Hyman <ma7520@hotmail.com>
Sent: Thursday, July 3, 2025 9:18 AM
To: Forte, Hope
Subject: [External] POC CALLED2CARE
Attachments: pro-lWgHRxm7.jpeg; pro-FCjdW7EC.jpeg; pro-pWxawfaP.jpeg; pro-ac51Vdcs.jpeg; pro-5z6PyhQP.jpeg; pro-0v9Wthdx.jpeg; pro-Y2t3VUM.jpeg

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