

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL046021 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____ | (X3) DATE SURVEY<br>COMPLETED<br><br>R<br>05/30/2025 |
|-----------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------------------------|------------------------------------------------------|

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

STEPHENSON FAMILY CARE HOME

316 EAST RICHARD STREET  
AHOSKIE, NC 27910

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                        | (X5)<br>COMPLETE<br>DATE |
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| C 000                    | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow up survey on 05/30/25.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | C 000               |                                                                                                                                                                                                                                                                                                 |                          |
| C 207                    | 10A NCAC 13G .0702 (f) Tuberculosis Test and Medical Examination<br><br>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination and Immunizations<br>(f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews, and interviews, the facility failed to ensure resident's FL-2's were completed with physician orders for 1 of 3 sampled residents (#3).<br><br>The findings are:<br><br>Review of Resident #3's current FI-2 dated 01/07/25 revealed:<br>-Diagnoses included hypertension, schizoaffective disorder bipolar type, asthma, and anal condyloma (anal condyloma are anal warts).<br>-There was not an order for Senna 8.6mg, take 1 tablet every day at 8:00am (Senna is used to treat<br>-There was not an order for Vitamin D3 1,000 units, take 1 tablet every day at 8:00am (Vitamin | C 207               | -The Administrator will ensure that FL-2's are clear with sufficient information from the physician. If not the Administrator will immediately contact the physician for clarification. Administrator will ensure Residents FL-2's will be completed and in compliance with physician's orders. |                          |

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

**RECEIVED**  
JUL 29 2025

*Gilda Murry* Administrator

7/23/25

If continuation sheet 1 of 3

Reviewed and Acknowledged SJS

7/31/25

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>FCL046021 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   |                          | (X3) DATE SURVEY<br>COMPLETED<br><br>R<br>05/30/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>STEPHENSON FAMILY CARE HOME |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>316 EAST RICHARD STREET<br>AHOSKIE, NC 27910                                    |                          |                                                      |
| (X4) ID<br>PREFIX<br>TAG                                        | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                      |
| C 207                                                           | <p>Continued From page 1</p> <p>D3 is used to treat constipation).</p> <p>Review of Resident #3's physician order sheet dated 04/08/25 revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for Senna 8.6mg, take 1 tablet every day for supplement at 8:00am (Senna is used to treat</li> <li>-There was an order for Vitamin D3 1,000 units, take 1 tablet every day for supplement at 8:00am (Vitamin D3 is used to treat bone structure).</li> </ul> <p>Review of Resident #3's March 2025 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Senna 8.6mg, take 1 tablet once a day at 8:00am.</li> <li>-Senna 8.6mg was documented as administered at 8:00am from 03/01/25 to 03/31/25.</li> <li>-There was an entry for Vitamin D3 1,000 units, take 1 tablet once a day at 8:00am.</li> <li>-Vitamin D3 1,000 was documented as administered at 8:00am from 03/01/25 to 03/31/25.</li> </ul> <p>Review of Resident #3's April 2025 MAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Senna 8.6mg, take 1 tablet once a day at 8:00am.</li> <li>-Senna 8.6mg was documented as administered at 8:00am from 04/01/25 to 04/30/25.</li> <li>-There was an entry for Vitamin D3 1,000 units, take 1 tablet once a day at 8:00am.</li> <li>-Vitamin D3 1,000 was documented as administered at 8:00am from 04/01/25 to 04/30/25.</li> </ul> <p>Review of Resident #3's May 2025 MAR revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for Senna 8.6mg, take 1 tablet once a day at 8:00am.</li> <li>-Senna 8.6mg was documented as administered</li> </ul> | C 207                                                                  |                                                                                                                          |                          |                                                      |

Division of Health Service Regulation

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>STEPHENSON FAMILY CARE HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>316 EAST RICHARD STREET</b><br><b>AHOSKIE, NC 27910</b>                      |                          |                                                                 |
| (X4) ID<br>PREFIX<br>TAG                                               | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE |                                                                 |
| C 207                                                                  | <p>Continued From page 2</p> <p>at 8:00am from 05/01/25 to 05/29/25.</p> <ul style="list-style-type: none"> <li>-There was an entry for Vitamin D3 1,000 units, take 1 tablet once a day at 8:00am.</li> <li>-Vitamin D3 1,000 was documented as administered at 8:00am from 05/01/25 to 05/29/25.</li> </ul> <p>Observation of medications on hand for Resident #3 on 05/30/25 at 1:30pm revealed:</p> <ul style="list-style-type: none"> <li>-There were 10 tablets of Senna 8.6mg on hand.</li> <li>-There were 10 tablets of Vitamin D3 1,000 on hand.</li> </ul> <p>Telephone interview with a pharmacist with the facility's contracted pharmacy on 05/30/25 at 10:32am revealed:</p> <ul style="list-style-type: none"> <li>-The pharmacy dispensed 30 tablets of Senna 8.6mg 05/01/25.</li> <li>-The pharmacy dispensed 30 tablets of Vitamin D3 1,000 units on 05/01/25.</li> <li>-The pharmacy had not received a copy of Resident #3's FL-2 dated 01/07/25.</li> </ul> <p>Interview with the Administrator on 05/30/25 at 1:40pm revealed:</p> <ul style="list-style-type: none"> <li>-She had all medications to administer to the resident per his MAR and his physician orders.</li> <li>-She should have caught her mistake when she completed a cart audit.</li> <li>-She completed cart audits which included reviewing and comparing the resident's physician orders, the MAR and medications on hand.</li> <li>-She had forgotten to send Resident #3's FL-2 to the pharmacy.</li> </ul> | C 207                                                                      |                                                                                                                          |                          |                                                                 |