

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL080004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/07/2025
NAME OF PROVIDER OR SUPPLIER MARY'S FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 485 LONG FERRY ROAD SALISBURY, NC 28144		
(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 10/07/25.	C 000		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#1) related to a dose change for a diuretic and administering a discontinued antipsychotic medication. The findings are: Review of Resident #1's current FL2 dated 07/28/25 revealed: -Diagnoses included congestive heart failure (CHF), diabetes mellitus (DM), bipolar disorder, hyperlipidemia, and hypertension. -There was an order for furosemide (a diuretic used to treat fluid retention) 80mg 1 tablet every morning. -There was an order for olanzapine (an antipsychotic that may be used to treat bipolar disorder) 10mg 1 tablet every evening.	C 330		

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

TITLE

(X6) DATE

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C 330	Continued From page 1 a. Review of Resident #1's record revealed a signed physician's order dated 09/11/25 for furosemide 40mg 1 tablet daily. Review of Resident #1's August 2025 Medication Administration Record (MAR) revealed: -There was an entry for furosemide 80mg and scheduled to be administered at 8:00am. -Furosemide was documented as administered for 31 of 31 opportunities from 08/01/25 to 08/31/25. Review of Resident #1's September 2025 MAR revealed: -There was an entry for furosemide 80mg and scheduled to be administered at 8:00am. -There was no entry for furosemide 40mg scheduled to be administered. -Furosemide 80mg 1 tablet every morning was documented as administered for 22 of 22 opportunities from 09/01/25 to 09/22/25. -Resident #1 was out-of-facility (OOF) from 09/23/25 to 09/30/25. Review of Resident #1's October 2025 MAR from 10/01/25 to 10/06/25 revealed: -There was an entry for furosemide 80mg and scheduled to be administered at 8:00am. -There was no entry for furosemide 40mg scheduled to be administered. -Furosemide 80mg 1 tablet every morning was documented as administered for 6 of 6 opportunities from 10/01/25 to 10/06/25. Observation of Resident #1's medications on hand on 10/07/25 at 3:00pm revealed: -Furosemide 80mg tablets were available for administration. -There was a pill bottle of furosemide 80mg	C 330		

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C 330	Continued From page 2 dispensed on 09/12/25 with 7 of 30 tablets remaining. -There was also a bubble pack of furosemide 80mg dispensed on 10/06/25 with 16 of 16 tablets remaining. Interview with Resident #1 on 10/07/25 at 3:15pm revealed: -She was not aware her primary care provider (PCP) had changed her furosemide on 09/11/25. -She had not experienced dizziness or urination issues within the last several months. Telephone interview with the facility's contracted pharmacy consultant on 10/07/25 at 12:27pm revealed: -There was an active order for Resident #1 for furosemide 80mg 1 tablet every morning. -There was no order for furosemide 40mg. -The pharmacy last dispensed 30 tablets of furosemide 80mg on 09/12/25 and 16 tablets of furosemide 80mg on 10/06/25. -She expected the facility to follow-up with her when orders were changed by residents' PCP. Telephone interview with Resident #1's PCP on 10/07/25 at 1:10pm revealed: -She had ordered Resident #1's furosemide to be changed from 80mg to 40mg and she expected the facility to follow up with her office related to questions or concerns with medication orders. -The PCP expected the facility to follow her orders to change Resident #1's furosemide and the PCP would expect possible light-headedness and increased urination if the facility failed to follow her order. Interview with the Administrator on 10/07/25 at 3:25pm revealed she was not aware Resident #1's PCP had changed her furosemide 80mg to	C 330		

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C 330	Continued From page 3 40mg on the physician's orders from 09/11/25 and she had overlooked that detail. Refer to the interview with the Administrator on 10/07/25 at 3:25pm. b. Review of Resident #1's record revealed a signed physician's order dated 09/11/25 for olanzapine 10mg every evening to be discontinued. Review of Resident #1's August 2025 MAR revealed: -There was an entry for olanzapine 10mg scheduled to be administered at 8:00pm. -Olanzapine was documented as administered for 31 of 31 opportunities at 8:00pm from 08/01/25 to 08/31/25. Review of Resident #1's September 2025 MAR revealed: -There was an entry for olanzapine 10mg scheduled to be administered at 8:00pm. -Olanzapine was documented as administered for 22 of 22 opportunities at 8:00pm from 09/01/25 to 09/22/25. -Resident #1 was OOF from 09/23/25 to 09/30/25. -There was no entry on the MAR to discontinue olanzapine. Review of Resident #1's October 2025 MAR from 10/01/25 to 10/06/25 revealed: -There was an entry for olanzapine 10mg scheduled to be administered at 8:00pm. -Olanzapine was documented as administered for 6 of 6 opportunities at 8:00pm from 10/01/25 to 10/06/25. -There was no entry on the MAR to discontinue olanzapine.	C 330		

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C 330	Continued From page 4 Observation of Resident #1's medications on hand on 10/07/25 at 3:00pm revealed: -Olanzapine 10mg was available for administration. -There was a bubble pack of olanzapine 10mg dispensed on 09/16/25 with 16 of 30 tablets remaining. Interview with Resident #1 on 10/07/25 at 3:15pm revealed: -She was not aware her PCP had changed her olanzapine on 09/11/25. -She had not experienced issues with drowsiness or fatigue within the last several months. Telephone interview with the facility's contracted pharmacy consultant on 10/07/25 at 12:27pm revealed: -There was no discontinue order from Resident #1's PCP for olanzapine on 09/11/25. -There was an active order for Resident #1's olanzapine 10mg every evening and the pharmacy last dispensed 30 tablets of olanzapine 10mg on 09/16/25. -She expected the facility to follow-up with her when orders were changed by residents' PCP. Telephone interview with Resident #1's PCP on 10/07/25 at 1:10pm revealed: -She had ordered Resident #1's olanzapine 10mg to be discontinued on 09/11/25 and she expected the facility to follow up with her office related to questions or concerns with medication orders. -She expected the facility to follow her orders to discontinue Resident #1's olanzapine. -She would have expected increased drowsiness and lack of energy if the facility failed to discontinue Resident #1's olanzapine..	C 330			

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C 330	Continued From page 5 Interview with the Administrator on 10/07/25 at 3:25pm revealed she was not aware Resident #1's PCP had discontinued her olanzapine 10mg on the physician's orders from 09/11/25 and she had overlooked that detail. Refer to the interview with the Administrator on 10/07/25 at 3:25pm. Interview with the Administrator on 10/07/25 at 3:25pm revealed: -She was responsible for reviewing the physician orders for medication changes and she was responsible for providing the medication changes ordered to the pharmacy. -She was responsible for adding and for removing medications from the MAR based on PCP orders. -She knew she should have reviewed the PCP orders and she should have changed the MAR, but it was an oversight.	C 330			