STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL054061	A. BUILDING: _____ B. WING _____	11/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARNES FAMILY CARE HOME	1106 EAST CASWELL STREET KINSTON, NC 28502

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Lenoir County Department of Social Services conducted an annual survey on November 12, 2025.	C 000		
C 320	10A NCAC 13G .1002 (f) Medication Orders 10A NCAC 13G .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration, are reviewed and signed by the resident's physician or prescribing practitioner at least every six months This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medication orders were signed every 6 months and maintained in the residents' records for 3 of 3 sampled residents (#1, #2, #3). The findings are: 1. Review of Resident #1's current FL-2 dated 03/26/25 revealed: -Diagnoses included Fragile X Syndrome, attention deficit hyperactive disorder (ADHD), sleep disorder, anxiety and depression. -There was an order for fluoxetine (fluoxetine is an anti-depressant) 20mg, take one capsule daily. -There was an order for methylphenidate (methylphenidate is used to treat ADHD) 50mg, take one twice daily 30 minutes before breakfast and 3:00pm. -There was an order for Trazodone (trazadone is used to treat depression and insomnia) 50mg, take one tablet at bedtime.	C 320	Administrator had in-serviced the supervisors-in-charge on the importance of obtaining signed medication orders every 6 months and maintaining current medication orders for all residents at the facility on 11-20-2025. Every 3 months, supervisors-in-charge will review signed medication orders for all residents to ensure compliance and will discuss the outcome with the administrator. All residents will have current medication orders signed by the physician for all residents by 1/10/2026.	

Reviewed and Acknowledged MW 01/08/26

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C 320	Continued From page 1 -There was an order for Asper creme with lidocaine (a topical product used for temporary relief of muscle and arthritic pain), to apply to right shoulder as needed (PRN) for pain. Review of Resident #1's record revealed that there was no signed physician order sheet for Resident #1 within the past 6 months. A signed physician's order sheet for Resident #1 was requested on 11/12/25 at 9:03am and was not provided by survey exit. Refer to interview with the Supervisor in Charge (SIC) on 11/12/25 at 1:32pm. Refer to interview with the Administrator on 11/12/25 at 1:36pm. 2. Review of Resident #2's FL-2 dated 01/29/25 revealed: -Diagnoses included unspecified intellectual disabilities, seizure, hypercholesterolemia, schizophrenia, history of spinal cord compression/back pain. -The recommended level of care was domiciliary/family care home. -There was an order for Aspirin 81mg tablet once daily (Aspirin 81mg can be used to decrease the risk of cardiovascular events). -There was an order for Simvastatin 20mg tablet once daily (Simvastatin can be used to lower LDL cholesterol and prevent coronary heart disease). -There was an order for Benztropine Mesylate 1 mg tablet at bedtime (benztropine can be used to treat muscle stiffness or tremors). -There was an order for Potassium Citrate 15mg tablet four times a day(potassium citrate can be used to treat gout, kidney stones, or high levels of acid in the body).	C 320		

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C 320	Continued From page 2 -There was an order for Divalproex Sodium delayed Release 250 mg tablet take three tablets two times a day (Divalproex Sodium is medication that can be given to treat seizures, manage manic episodes, or prevent migraine headaches). -There was an order for Carbamazepine extended release 200mg tablet take two tablets twice a day (Carbamazepine can be used to treat seizures or nerve pain). -There was an order for Haloperidol 5mg tablet take one at bedtime (Haloperidol is an antipsychotic medication that can be used to treat schizophrenia). Review of Resident #2's record revealed there was no signed physician review of Resident #2's medications within the past 6 months. Refer to interview with the Supervisor in Charge (SIC) on 11/12/25 at 1:32pm. Refer to interview with the Administrator on 11/12/25 at 1:36pm. 3. Review of Resident #3's FL-2 dated 02/20/25 revealed: -Diagnoses included moderate intellectual disability and cerebral palsy. -The recommended level of care was domiciliary/family care home. -There was an order for Cetirizine tablet 10mg once daily (Cetirizine is medication used to treat allergy symptoms). Review of Resident #3's record revealed there was no signed physician review of Resident #3's medications within the past 6 months. Refer to interview with the Supervisor in Charge (SIC) on 11/12/25 at 1:32pm.	C 320		

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C 320	Continued From page 3 Refer to interview with the Administrator on 11/12/25 at 1:36pm. Interview with a Supervisor in Charge (SIC) on 11/12/25 at 1:32pm revealed: -He was not aware that signed physicians' orders were required for the residents every 6 months. -He thought the other SIC may have the residents signed physicians' order sheets with her because she transported the residents to their provider appointments during the day. -The other SIC was currently out transporting the residents. Interview with the Administrator on 11/12/25 at 1:36pm revealed: -The day shift SIC was responsible for making sure physicians orders were signed by the residents' primary care provider every 6 months since she transported the residents to their provider appointments. -She did periodic reviews of the residents' records, and it was ultimately her responsibility as the Administrator to make sure there were signed physicians' orders in the residents' record. -She was not aware that there were no signed physicians order sheets in the residents' records.	C 320		
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	C 330		

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C 330	Continued From page 4	C 330		

(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#1) for a medication used to treat attention deficit hyperactive disorder (ADHD).

The findings are:

Review of the facility's undated medication administration policy dated revealed:
-Prescription or non-prescription drugs shall only be administered to a member on the written order of a person authorized by law to prescribe drugs.
-A medication administration record (MAR) of all drugs administered to each member must be kept current.
-Medications administered shall be recorded immediately after administration.
-The MAR is to include the member's name, name, strength, quantity of drug, date and time of the medication administration, and the names or initials of the individual administering the medication.

Review of Resident #1's current FL2 dated 03/26/25 revealed:
-Diagnosis included ADHD.
-There was an order for methylphenidate (used to treat ADHD) 50mg, twice a day 30 minutes before breakfast and at 3:00pm.

Review of a signed prescription for Resident #1 dated 10/15/25 revealed an order for Ritalin (the brand name for methylphenidate) 20mg, take one

C330

Administrator had in-serviced the supervisors-in-charge on the importance of ensuring medications are administered as ordered as well as recording immediately after administering medications on 11-20-2025. Before submitting FL2s for doctor's signature, administrator will review all information written by staff (including medication name, strength, and directions) on the FL2 to ensure accuracy. Every month, supervisors-in-charge will review all MARS and to ensure medications are administered as ordered as well as documented timely. As of 1/2/2026, all medications are administered and documented as ordered. During the month of October 2025 and November 2025 the administration times for on methylphenidate for Resident #1 were changed from 7a and 3p during previous months to 8a and 8p twice a day. The pharmacy was called to inquire why there was a change on the MAR. The pharmacist stated that these times were set by default and the pharmacist will change the times back on the MAR for Resident #1's methylphenidate to 7a and 3p.

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C 330	Continued From page 5 tablet two times per day on an empty stomach for a quantity of 60 tablets for a 30-day supply. Review of Resident #1's October 2025 MAR revealed: -There was entry for methylphenidate 20mg, take one tablet twice a day on an empty stomach scheduled at 8:00am and 8:00pm -Methylphenidate 20mg was documented as administered at 8:00am on 10/01/25 through 10/31/25. -Methylphenidate 20mg was documented as administered at 8:00pm on 10/01/25 through 10/30/25. -Methylphenidate 20mg was not documented as administered at 8:00pm on 10/31/25 with no exception documented. -Methylphenidate 20mg was documented as administered on 61 occasions out of 62 opportunities from 10/01/25 at 8:00am through 8:00pm on 10/31/25. Review of Resident #1's November 2025 MAR revealed: -There was entry for methylphenidate 20mg, take one tablet twice a day on an empty stomach scheduled at 8:00am and 8:00pm -Methylphenidate 20mg was documented as administered at 8:00am on 11/01/25 through 11/11/25. -Methylphenidate 20mg was documented as administered at 8:00pm on 11/01/25 through 11/10/25. -Methylphenidate 20mg was not documented as administered at 8:00am on 11/12/25 with no exception documented. -Methylphenidate 20mg was not documented as administered at 8:00pm on 11/11/25 with no exception documented. -Methylphenidate 20mg was documented as	C 330		

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C 330	Continued From page 6 administered on 21 occasions out of 23 opportunities from 11/01/25 at 8:00am through 8:00am on 11/12/25. Review of the controlled substance (CSL) log for methylphenidate 20mg for Resident #1 revealed: -The start date of the CSL for methylphenidate 20mg 60 tablets dispensed on 10/15/25, to take twice daily was documented as 10/27/25 at 8:00pm with 59 tablets remaining. -Methylphenidate 20mg was not documented as signed out on 10/31/25 at 8:00am and 8:00pm. -Methylphenidate 20mg was not documented as signed out on 11/11/25 at 8:00pm. -Methylphenidate 20mg was not documented as signed out on 11/12/25 at 8:00am. -The remaining count for methylphenidate 20mg tablets was documented as 32 tablet on 11/11/25 at 8:00am. Observation of Resident #1's medications on hand on 11/12/25 at 10:08am revealed: -There were 2 bubble packages of methylphenidate 20mg tablets, 1 package with 30 tablets dispensed on 10/15/25 with no tablets left and a second package of 30 tablets dispensed on 10/15/25 with 30 tablets left with instructions to take 1 tablet twice daily on an empty stomach. -If methylphenidate 20mg had been administered as ordered twice daily from 10/27/25 at 8:00pm through 11/12/25 at 8:00am, there should have been 28 tablets of methylphenidate 20mg remaining for Resident #1. Telephone interview with the pharmacist at the facility's contracted pharmacy on 11/12/25 at 10:52am revealed: -An order was received for Resident #1 for methylphenidate 20mg, take one tablet twice daily on 04/12/25.	C 330		

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C 330	Continued From page 7 -Methylphenidate 20mg was dispensed for Resident #1 on 10/15/25 to take one tablet twice daily on an empty stomach for a quantity of 60 tablets for a thirty-day supply and was delivered to the facility on 10/17/25. Interview with Resident #1 on 11/12/25 at 9:07am revealed: -He took medication twice a day. -He was not certain what medications he took and why. -The day shift Supervisor-in-Charge (SIC) administered his medications. -He had his medications this morning. -He did not think he had missed any of his medications. Interview with the day shift Supervisor-in-Charge (SIC) on 11/12/25 at 10:21am revealed: -She administered the residents morning and evening medications. -She always compared the residents' medications to their MAR before administering medications and documented on the MAR immediately after she administered their medications, -If a resident had a controlled medication, the medication was signed out on the corresponding CSL. -She was certain she administered Resident #1's methylphenidate 20mg on 10/31/25, 11/11/25 and on 11/12/25. -She thought she probably just got in a hurry and failed to document Resident #1's methylphenidate on the MAR and on the CSL. Interview with the Administrator on 11/12/25 at 1:32pm revealed: -The two SIC administered medications to the residents. -The SIC was expected to watch the resident take	C 330		

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C 330	Continued From page 8 their medications after they were administered and immediately document on the MAR that the medication was administered. -If a medication was not administered for any reason, the SIC was expected to document a reason why a medication was not administered. -She expected the residents to receive their medications as ordered. -Staff had just had an in-service on the importance of documentation.	C 330		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 1 sampled residents (#1) with orders for a controlled substance used to treat attention deficit hyperactive disorder (ADHD). The findings are: Review of Resident #1's current FL2 dated 03/26/25 revealed: -Diagnosis included ADHD. -There was an order for methylphenidate 50mg, twice a day 30 minutes before breakfast and at 3:00pm.	C 367	C367 Effective 1/10/2026, all of the clients' records will be stored at the facility in a locked cabinet to ensure readily retrievable records are accessible. The supervisors-in charge will check every quarter to ensure that all clients' records are stored properly at the facility.	

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C 367	Continued From page 9 Review of Resident #1's record on 11/12/25 revealed there was no signed physicians order sheet for Resident #1. Review of a signed prescription for Resident #1 dated 10/15/25 revealed an order for Ritalin (the brand name for methylphenidate) 20mg, take one tablet two times per day on an empty stomach for a quantity of 60 tablets for a 30-day supply. Review of Resident #1's October 2025 MAR revealed: -There was entry for methylphenidate 20mg, take one tablet twice a day on an empty stomach scheduled at 8:00am and 8:00pm -Methylphenidate 20mg was documented as administered at 8:00am on 10/01/25 through 10/31/25. -Methylphenidate 20mg was documented as administered at 8:00pm on 10/01/25 through 10/30/25. -Methylphenidate 20mg was not documented as administered at 8:00pm on 10/31/25 with no exception documented. Review of Resident #1's November 2025 MAR revealed: -There was entry for methylphenidate 20mg, take one tablet twice a day on an empty stomach scheduled at 8:00am and 8:00pm -Methylphenidate 20mg was documented as administered at 8:00am on 11/01/25 through 11/11/25. -Methylphenidate 20mg was documented as administered at 8:00pm on 11/01/25 through 11/10/25. -Methylphenidate 20mg was not documented as administered at 8:00am on 11/12/25 with no exception documented.	C 367		

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C 367	Continued From page 10 -Methylphenidate 20mg was not documented as administered at 8:00pm on 11/11/25 with no exception documented. -Methylphenidate 20mg was documented as administered on 21 of 23 opportunities from 11/1/25 at 8:00am through 8:00am on 11/12/25. Review of the controlled substance log (CSL) for methylphenidate 20mg for Resident #1 revealed: -The start date of the CSL for methylphenidate 20mg 60 tablets dispensed on 10/15/25, to take twice daily was documented as administered on 10/27/25 at 8:00pm. -Methylphenidate 20mg was not documented as signed out on 10/31/25 at 8:00am and 8:00pm. -Methylphenidate 20mg was not documented as signed out on 11/11/25 at 8:00pm. -Methylphenidate 20mg was not documented as signed out on 11/12/25 at 8:00am. -The remaining count for methylphenidate 20mg tablets was documented as 32 tablet on 11/11/25 at 8:00am. Observation of Resident #1's medications on hand on 11/12/25 at 10:08am revealed: -There were 2 bubble packages of methylphenidate 20mg tablets, 1 package with 30 tablets dispensed on 10/15/25 with no tablets remaining and a second package of 30 tablets dispensed on 10/15/25 with 30 tablets remaining with instructions to take 1 tablet twice daily on an empty stomach. -There was a 2-tablet discrepancy between Resident #1's methylphenidate on hand and the CSL for the methylphenidate, with there being 30 tablets of methylphenidate 20mg available for Resident #1 and the CSL reflected a remaining balance of 32 tablets of methylphenidate 20mg for Resident #1.	C 367		

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C 367	Continued From page 11 Telephone interview with the pharmacist at the facility's contracted pharmacy on 11/12/25 at 10:52am revealed: -There was no order for methylphenidate 50mg for Resident #1. -An order was received for Resident #1 for methylphenidate 20mg, take one tablet twice daily on 04/12/25. -Methylphenidate 20mg was dispensed for Resident #1 on 10/15/25 to take one tablet twice daily on an empty stomach for a quantity of 60 tablets for a thirty-day supply and was delivered to the facility on 10/17/25. Interview with Resident #1 on 11/12/25 at 9:07am revealed: -He took medication twice a day. -He was not certain what medications he took and why. -The day shift Supervisor-in-Charge (SIC) administered his medications. -He had his medications this morning. -He did not think he had missed any of his medications. Interview with the day shift SIC on 11/12/25 at 10:21am revealed: -She administered the residents morning and evening medications. -She always compared the residents' medications to their MAR before administering medications and documented on the MAR immediately after she administered their medications, -She and the night shift SIC counted the controlled medications at the change of each shift. -She had not noticed that the count was off for Resident #1's methylphenidate. -If a resident had a controlled medication, the medication was signed out on the corresponding	C 367		

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C 367	Continued From page 12 CSL. -She was certain she administered Resident #1's methylphenidate 20mg on 10/31/25, 11/11/25 and on 11/12/25. -She thought she probably just got in a hurry and failed to document Resident #1's methylphenidate on the MAR and the CSL. Interview with the Administrator on 11/12/25 at 1:32pm revealed: -The two SIC could administer medications to the residents. -Controlled medications were to always be signed out on the CSL and the resident's medications on hand should always coincide with the CSL. -She was not aware there was a discrepancy in the methylphenidate on hand for Resident #1 and the corresponding CSL. -She felt it was an oversight on the SIC's part that she forgot to document Resident #1's methylphenidate on both the MAR and the CSL. -She expected controlled medications to be administered as ordered and signed out on the CSL.	C 367		