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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PANDORA FAMILY CARE HOME	924 HOBBS STREET CLAYTON, NC 27520

(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 February 26-27, 2026.	C 000		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to meet the acute health care needs for 1 of 3 residents (#3) sampled related to referrals for urology and neurology specialty evaluations. The findings are: Review of Resident #3's current FL-2 dated 09/05/25 revealed diagnoses included generalized anxiety disorder, major neurocognitive disorder, urinary incontinence, overactive bladder, essential hypertension, hyperlipidemia, tension-type headache, and chronic back pain. Review of the Resident Register for Resident #3 dated 07/12/23 revealed: -Resident #3 was admitted to the facility on 07/12/23. -Assistance required for Resident #3 included correspondence and scheduling appointments. Review of Resident #3's current care plan assessment dated 09/04/25 revealed: -Resident #3 was oriented. -Resident #3 required assistance with activities of	C 246		

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daily living including toileting, bathing, and grooming/personal hygiene.

a. Review of Resident #3's primary care provider (PCP) progress note dated 09/05/25 revealed:
-Resident #3 was seen for dizziness.
-The PCP documented "get neurology consult".

Interview with Resident #3 on 02/26/26 at 8:50am revealed:
-Staff transported him to medical appointments every three months and he did not know the doctor's name.
-He had virtual visits at the facility with a mental health provider.

Second interview with Resident #3 on 02/27/26 at 1:40pm revealed:
-His neuropathy was getting worse.
-There were times that "spells come over my knees and lose my balance", and there was a numbness in his knees.
-Sometimes when he raised his hands to reach for something, he felt like he was going to lose his balance.
-The feelings had been going on for a couple years but had gotten to the point where he did not have to raise his arms anymore.
-He had not told anybody about the "spells" that started about a month ago.

Review of Resident #3's record on 02/26/26 revealed there was no documentation for a neurology consultation.

Interview with the facility's Director on 02/26/26 at 3:25pm revealed:
-The Administrator was told by the PCP that a magnetic resonance imaging test (MRI) completed on 10/13/25 for Resident #3 revealed

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fluid behind the left ear.
-The Administrator thought the MRI addressed any concerns regarding the neurology consultation.

Interview with the Administrator on 02/27/26 at 12:25pm revealed:
-The PCP was responsible to send referrals to specialty providers.
-The specialty provider would contact her to schedule the appointment once the specialty provider office received the referral.
-The neurology consultation requested on 09/05/25 was probably sent to the specialty provider but she never got a call from the neurologist office.
-There had not been a neurology consultation completed for Resident #3.
-She knew the PCP request for a neurology consultation for Resident #3 was in the resident' record.
-She was responsible for reviewing physician/PCP notes when written in the resident record.
-She forgot to follow up on the neurology consultation request.
-She relied on the telephone call from the specialty provider to ensure referrals were scheduled.

Second interview with the Administrator on 02/27/26 at 12:45pm revealed:
-Resident #3's PCP ordered the neurology consult because the resident complained of dizziness.
-When she received the telephone call from the PCP to discuss the results of the MRI, the PCP did not indicate cancelling the neurology consultation and she did not discuss anything regarding the neurology consultation.

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C 246	Continued From page 3 Refer to the interview with the medication aide/personal care aide (MA/PCA) on 02/26/26 at 11:35am. Refer to the interview with the facility's Director on 02/26/26 at 12:33pm. Telephone interview with Resident #3's primary care provider (PCP) was unsuccessful on 02/27/26 at 12:38pm. b. Review of Resident #3's primary care provider (PCP) progress note dated 09/05/25 revealed: -Resident #3 was seen for incontinence. -The PCP documented "refer to urology". Interview with Resident #3 on 02/26/26 at 8:50am revealed: -Staff transported him to medical appointments every three months and he did not know the doctor's name. -He had virtual visits at the facility with a mental health provider. Second interview with Resident #3 on 02/27/26 at 1:40pm revealed: -He was urinating a lot. -He was wetting the bed about once or twice a week and use to wet the bed once a week. -He could not say how long he had been wetting the bed 1-2 times a week. -He felt like the bedwetting had been happening and gotten worse about 6-8 weeks. Review of Resident #3's record on 02/26/26 revealed there was no documentation for a urology consultation. Interview with the facility's Director on 02/26/26 at	C 246		

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C 246	Continued From page 4 3:23pm revealed: -Today (02/26/26) was the first day the facility had any follow-up regarding the urology referral. -He was unsure how or why the urology referral was missed. Interview with the Administrator on 02/27/26 at 12:25pm revealed: -The PCP was responsible to send referrals to specialty providers. -The specialty provider would contact her to schedule the appointment once the specialty provider office received the referral. -The urology consultation requested on 09/05/25 was probably sent to the specialty provider but she (Administrator) never got a call from the urologist office. -There had not been a urology consultation completed for Resident #3. -She knew the PCP request for a urology consultation for Resident #3 was in the resident's record. -She was responsible for reviewing physician/PCP notes when written in the resident record. -She forgot to follow up on the urology consultation request. -She relied on the telephone call from the specialty provider to ensure referrals were scheduled. Refer to the interview with the medication aide/personal care aide (MA/PCA) on 02/26/26 at 11:35am. Refer to the interview with the facility's Director on 02/26/26 at 12:33pm. Telephone interview with Resident #3's primary care provider (PCP) was unsuccessful on	C 246		

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C 246	Continued From page 5 02/27/26 at 12:38pm._____ Interview with the medication aide/personal care aide (MA/PCA) on 02/26/26 at 11:35am revealed the Administrator and Director scheduled all resident appointments. Interview with the facility's Director on 02/26/26 at 12:33pm revealed: -If a resident was referred to a specialist, the Administrator was the point of contact for scheduling the specialty appointment. -If the Administrator did not receive a telephone call from the specialty provider to schedule the appointment, the Administrator would follow up with the specialist "typically" within a 30-day period. -He or the Administrator transported residents to appointments.	C 246		
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 record reviews and interviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2, #3) including errors with a medication used to treat	C 330		

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overactive bladder (#3), pain (#2, #3), behaviors (#1, #2, #3), sleep disorders (#1, #2, #3), high blood pressure (#1), diabetes mellitus (#1, #2), muscle spasm (#2), and high cholesterol (#1).

The findings are:

Review of the facility medication policy revealed:
-Medications would be administered to residents as ordered by the resident's physicians.
-The facility would ensure compliance of the medication policy and procedure.
-The medication prescriber would be contacted by nursing for direction when delivery of a medication would be delayed or the medication was not available.
-If several consecutive doses of a vital medication was withheld, refused, or not available the physician would be notified, and nursing would document the notification and physician response.

1. Review of Resident #3's current FL-2 dated 09/05/25 revealed:
-Diagnoses included generalized anxiety disorder, major neurocognitive disorder, urinary incontinence, overactive bladder, essential hypertension, hyperlipidemia, tension-type headache, and chronic back pain.

Review of the Resident Register for Resident #3 revealed the resident was admitted to the facility on 07/12/23.

a. Review of a primary care provider (PCP) progress note for Resident #3 dated 09/05/25 revealed a note for "Gemtesa (used to treat overactive bladder) to help with urination".

Review of a PCP order for Resident #3 dated

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C 330	Continued From page 7 09/05/25 revealed an order for Gemtesa 75mg tablet daily. Review of a PCP order for Resident #3 dated 12/24/25 revealed: -Gemtesa 75mg tablet daily, quantity of 30 tablets were dispensed to the facility with one refill remaining. -There was a printed note on the prescription for "please follow up for further refills". Review of Resident #3's February 2026 medication administration record (MAR) revealed: -There was a printed entry for Gemtesa 75mg tablet daily, scheduled for administration at 8:00am. -There were medication aide (MA) initials circled from 02/01/26 through 02/10/26. Review of the medication notes documented on the back of the February 2026 MARs for Resident #3 revealed there was documentation that the Gemtesa 75mg tablets were "not delivered" 02/01/26 through 02/10/26. Interview with Resident #3 on 02/27/26 at 1:40pm revealed: -He did not remember the name of the medication he was prescribed for his bladder. -He did not know names of medications. -He had dementia. -He was urinating a lot. -He wet the bed about once or twice a week. -His neuropathy was getting worse. Interview with the Administrator on 02/27/26 at 9:41am revealed: -The MAs were good about telling her when medications were needed. -She found out on 01/27/26 that Resident #3's	C 330		

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Gemtesa was unavailable.
-She was notified by the MA again on 01/29/26 that Resident #3's Gemtesa medication was still unavailable.
-She contacted the PCP practice and left a message for the prescribing PCP but did not remember the specific date of contact.
-She found out that the prescribing PCP was no longer working at the medical practice but did not remember when she found that out.
-She finally called the PCP practice and spoke to someone who informed her that Resident #3 had been assigned another PCP and would need an appointment for the Gemtesa to be prescribed.
-Resident #3 had not missed any of the Gemtesa during January 2026.

b. Review of physician orders for Resident #3's dated 09/05/25 revealed:
-There was an order for Tylenol (used to treat pain) 650mg tablet twice a day.
-There was an order for Gabapentin (used to treat nerve pain) 600mg tablet three times a day.
-There was an order for Donepezil (generic for Aricept and used to treat cognitive disorders) 10mg tablet at bedtime.
-There was an order for Desyrel (generic for Trazadone and used to treat anxiety, depression, and inability to sleep) 75mg at bedtime.
-There was an order for Risperdal (used to treat behaviors) 1mg tablet at bedtime.
-There was an order for Melatonin (used to treat sleep disorders) 6mg at bedtime.

Review of Resident #3's December 2025 medication administration records (MARs) revealed:
-There was a printed entry for Tylenol 325mg two tablets twice a day, scheduled at 8:00am and 8:00pm, and with a circle surrounding the

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medication aide (MA) initials on 12/31/25 at 8:00pm.
-There was a printed entry for Gabapentin 600mg tablet three times a day, scheduled at 8:00am, 2:00pm, and 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 2:00pm and 8:00pm.
-There was a printed entry for Donepezil HCL 10mg tablet at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm.
-There was a printed entry for Desyrel 50mg take 1.5 tablets at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm.
-There was a printed entry for Risperdal 1mg tablet at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm.
-There was a printed entry for Melatonin 3mg take two tablets at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm.

Review of the 12/31/25 medication notes on the back of the December 2025 MARs for Resident #3 revealed there was documentation that the Tylenol 325mg tablets, Gabapentin 600mg tablets, Donepezil HCL 10mg tablet, Desyrel 50mg tablet, Risperdal 1mg tablet, and Melatonin 3mg tablets were "not delivered".

Interview with Resident #3 on 02/26/26 at 8:50am revealed:
-He was administered medications three times a day.
-He did not know the names of the medications he was administered.
-He did not know his doctor's name.
-He was seen by a doctor every three months.

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C 330	Continued From page 10 Refer to the interview with the personal care aide/medication aide (PCA/MA) on 02/26/26 at 2:30pm. Refer to the interview with the facility's Director on 02/26/26 at 3:58pm. Refer to the telephone interview with a pharmacy technician for the contracted pharmacy provider on 02/26/26 at 4:15pm. Refer to the interview with the Administrator on 02/27/26 at 9:01am. Attempted telephone interviews with Resident #3's PCP on 02/27/26 at 9:55am and 1:25pm were unsuccessful. 2. Review of Resident #1's current FL-2 dated 12/22/25 revealed diagnoses included schizoaffective disorder, diabetes mellitus type II, gastro-esophageal reflux disease, premature ventricular contractions, hypertension, hyperlipidemia, and urinary incontinence. Review of the Resident Register for Resident #1 revealed the resident was admitted to the facility on 10/05/22. Review of physician orders for Resident #1's dated 12/22/25 revealed: -There was an order for Metformin HCL (used to treat diabetes mellitus) extended release 500mg tablet twice a day. -There was an order for Metoprolol succinate (used to treat hypertension) extended release 100mg tablet twice a day. -There was an order for Atorvastatin (used to treat high cholesterol) 40mg tablet at bedtime.	C 330		

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C 330	Continued From page 11 -There was an order for Quetiapine (generic for Seroquel and used to treat anxiety, depression, and inability to sleep) 800mg at bedtime. -There was an order for Trazadone (used to treat depression) 50mg tablet at bedtime. Review of Resident #1's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Metformin HCL extended release 500mg tablet twice a day, scheduled at 8:00am and 8:00pm, and with a circle surrounding the medication aide (MA) initials on 12/31/25 at 8:00pm. -There was a printed entry for Metoprolol succinate extended release 100mg tablet twice a day, scheduled at 8:00am and 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm. -There was a printed entry for Atorvastatin 40mg tablet at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm. -There was a printed entry for Seroquel 400mg take two tablets at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm. -There was a printed entry for Trazadone 50mg tablet at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm. Review of the 12/31/25 medication notes on the back of the December 2025 MARs for Resident #1 revealed there was documentation that the Metformin HCL ER 500mg tablet, Metoprolol succinate ER 100mg tablet, Atorvastatin 40mg tablet, Seroquel 400mg tablets, and Trazadone 50mg tablet were "not delivered".	C 330		

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C 330	Continued From page 12 Interview with Resident #1 on 02/26/26 at 9:00am revealed: -He was prescribed several different medications. -He could not think of the names of all the medications he was prescribed. Refer to the interview with the personal care aide/medication aide (PCA/MA) on 02/26/26 at 2:30pm. Refer to the interview with the facility's Director on 02/26/26 at 3:58pm. Refer to the telephone interview with a pharmacy technician for the contracted pharmacy provider on 02/26/26 at 4:15pm. Refer to the interview with the Administrator on 02/27/26 at 9:01am. Attempted telephone interview with Resident #1's PCP on 02/27/26 at 1:18pm was unsuccessful. 3. Review of Resident #2's current FL-2 dated 10/08/25 revealed: -Diagnoses included major depression, generalized anxiety disorder, major neurocognitive disorder, chronic obstructive pulmonary disease, history of lung cancer, urinary retention, urinary incontinence, hypertension, and chronic back pain. Review of the Resident Register for Resident #2 revealed the resident was admitted to the facility on 08/05/22. Review of physician orders for Resident #2's dated 10/08/25 revealed: -There was an order for Metformin (used to treat diabetes mellitus) 1000mg tablet twice a day.	C 330		

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C 330	Continued From page 13 -There was an order for Ibuprofen (used to treat pain) 800mg tablet three times a day. -There was an order for Buspar (used to treat anxiety) 15mg tablet two times a day. -There was an order for Seroquel (generic for Seroquel and used to treat anxiety, depression, and inability to sleep) 50mg at bedtime. -There was an order for Remeron (used to treat depression) 30mg tablet at bedtime. -There was an order for Tizanidine HCL (used to treat muscle spasm) 4mg tablet three times a day. Review of Resident #2's December 2025 medication administration records (MARs) revealed: -There was a printed entry for Metformin 1000mg tablet twice a day, scheduled at 8:00am and 8:00pm, and with a circle surrounding the medication aide (MA) initials on 12/31/25 at 8:00pm. -There was a printed entry for Ibuprofen 800mg tablet three times a day, scheduled at 8:00am, 2:00pm, and 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 2:00pm and 8:00pm. -There was a printed entry for Buspar 15mg tablet two times a day, scheduled at 8:00am and 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm. -There was a printed entry for Seroquel 50mg at dinner, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm. -There was a printed entry for Remeron 30mg tablet at bedtime, scheduled at 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 8:00pm. -There was a printed entry for Tizanidine HCL 4mg tablet three times a day, scheduled at	C 330		

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C 330	Continued From page 14 8:00am, 2:00pm, and 8:00pm, and with a circle surrounding the MA initials on 12/31/25 at 2:00pm and 8:00pm. Review of the 12/31/25 medication notes on the back of the December 2025 MARs for Resident #1 revealed there was documentation that the Metformin 1000mg tablet, Ibuprofen 800mg tablet, Buspar 15mg tablet, Seroquel 50mg tablet, Remeron 30mg tablet, and Tizanidine HCL 4mg tablet were "not delivered". Interview with Resident #2 on 02/26/26 at 10:36am revealed he did not know the names of all the medications he was prescribed. Refer to the interview with the personal care aide/medication aide (PCA/MA) on 02/26/26 at 2:30pm. Refer to the interview with the facility's Director on 02/26/26 at 3:58pm. Refer to the telephone interview with a pharmacy technician for the contracted pharmacy provider on 02/26/26 at 4:15pm. Refer to the interview with the Administrator on 02/27/26 at 9:01am. Attempted telephone interview with Resident #2's PCP on 02/27/26 at 12:40pm was unsuccessful. _____ Interview with the personal care aide/medication aide (PCA/MA) on 02/26/26 at 2:30pm revealed: -A circle around initials on the medication administration record (MAR) meant the medication was not administered. -She had to count medications and call the Administrator when her work shift cycle began.	C 330		

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C 330	Continued From page 15 -When a medication was not available in the facility, she contacted the Administrator. -She was instructed by the Administrator to not administer medications on 12/31/25 if resident's current month supply of medications were finished and should wait to administer medications from the on-hand January 2026 medication supply until 01/01/26. Interview with the facility's Director on 02/26/26 at 3:58pm revealed: -A 30-day supply of residents' medications were delivered to the facility by the contracted provider pharmacy every 30 days. -Medications were delivered to the facility within the last week of the outgoing month. -At shift change, medications were counted to ensure there were no missing medications. -Medications dispensed by the pharmacy for the upcoming month were started on the first day of that month which helped the facility keep up with the medication count on hand. -The residents at the facility missed their medications for one day on 12/31/25 because the packaged medications for the upcoming month started on the first day of that month and the December 2025 packaged medications ended on 12/30/25. -The Administrator decided the medications due on 12/31/25 would not be administered because there were no medications packaged for 12/31/25 in the December 2025 pharmacy dispensed medication packages. -The January 2026 pharmacy packaged medications were available in the facility on 12/31/25. -The facility was responsible to make sure residents' medications were administered as ordered. -He was unsure why the Administrator made the	C 330		

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decision not to administer medications on 12/31/25.
-He spoke to the pharmacy representative today (02/26/26) and was told insurance would not allow for medications to be filled in a 31-day supply so the facility should start the upcoming months medications so residents would not miss any medications.

Telephone interview with a pharmacy technician for the contracted pharmacy provider on 02/26/26 at 4:15pm revealed:
-She was unsure why the facility residents' medications were not administered on 12/31/25.
-Beginning 12/01/25, the facility was notified that insurance would not allow for more than a 30-day supply of medications to be dispensed.
-The facility should start a new medication package once the current medication package was completed.
-The pharmacy tried to deliver medications to the facility 4 - 7 days before the upcoming month begins.
-Residents should never go without their mediations being administered.

Interview with the Administrator on 02/27/26 at 9:01am revealed:
-A circle around the MA initials meant the medication was not administered because of a refusal or unavailable medication.
-On 12/31/25, some medications for the facility residents were not administered because the medications were unavailable.
-She told the MA that the January 2026 medication supply could not be used until January 2026 because the "medication counts for January 2026 would be off".
-The batch delivery of January 2026 medications were available in the facility and were delivered

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C 330	Continued From page 17 around 12/24/25 or 12/25/25. -The residents should not miss any medications. -The facility was supposed to start the upcoming months medication supply as soon as the current medication supply was completed to prevent missed medication. -The pharmacy instructed the facility not to focus on the medications as the month supply, but to focus on the medication. -She had not notified the primary care provider (PCP) of any missed medications and thought the PCP would have given her instructions to administer medications to the residents from the supply available in the facility to prevent missed medications. -She expected medications available in the facility to be administered to the residents.	C 330		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and	C 375		

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C 375	Continued From page 18 medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and, (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and, (C) documenting the results of the medication review in the resident's record; This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a licensed pharmacist, provider, or registered nurse completed a quarterly on-site medication review for 3 of 3 sampled residents (#1, #2, #3). The findings are: 1. Review of Resident #1's current FL-2 dated 12/22/25 revealed diagnoses included schizoaffective disorder, diabetes mellitus type II, gastro-esophageal reflux disease, premature ventricular contractions, hypertension, hyperlipidemia, and urinary incontinence. Review of the Resident Register for Resident #1 revealed the resident was admitted to the facility on 10/05/22. Review of Resident #1's drug regimen reviews revealed pharmacy drug reviews were not conducted quarterly as follows:	C 375		

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C 375	Continued From page 19 -There was a pharmacy drug review completed on 03/21/25. -The next pharmacy drug review was completed on 07/23/25, a total of four months after the 03/21/25 pharmacy drug review. -There was a subsequent drug review completed on 12/29/25, a total of five months after the 07/23/25 pharmacy drug review. -There were no recommendations documented for the 03/21/25, 07/23/25, or 12/29/25 pharmacy drug reviews. Refer to the interview with the Administrator on 02/27/26 at 10:05am. Refer to the interview with the contracted pharmacy provider registered nurse (RN) on 02/27/26 at 10:11am. 2. Review of Resident #2's current FL-2 dated 10/08/25 revealed diagnoses included major depression, generalized anxiety disorder, major neurocognitive disorder, chronic obstructive pulmonary disease, history of lung cancer, urinary retention, urinary incontinence, hypertension, and chronic back pain. Review of the Resident Register for Resident #2 revealed the resident was admitted to the facility on 08/04/22. Review of Resident #2's drug regimen reviews revealed pharmacy drug reviews were not conducted quarterly as follows: -There was a pharmacy drug review completed on 03/21/25. -The next pharmacy drug review was completed on 07/23/25, a total of four months after the 03/21/25 pharmacy drug review. -There was a subsequent drug review completed	C 375		

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on 12/29/25, a total of five months after the 07/23/25 pharmacy drug review.
-There were recommendations documented on the 12/29/25 pharmacy drug review for Resident #2 that were completed.

Refer to the interview with the Administrator on 02/27/26 at 10:05am.

Refer to the interview with the contracted pharmacy provider registered nurse (RN) on 02/27/26 at 10:11am.

3. Review of Resident #3's current FL-2 dated 09/05/25 revealed diagnoses included generalized anxiety disorder, major neurocognitive disorder, urinary incontinence, overactive bladder, essential hypertension, hyperlipidemia, tension-type headache, and chronic back pain.

Review of the Resident Register for Resident #3 revealed the resident was admitted to the facility on 07/12/23.

Review of Resident #3's drug regimen reviews revealed pharmacy drug reviews were not conducted quarterly as follows:
-There was a pharmacy drug review completed on 03/21/25.
-The next pharmacy drug review was completed on 07/23/25, a total of four months after the 03/21/25 pharmacy drug review.
-There was a subsequent drug review completed on 12/29/25, a total of five months after the 07/23/25 pharmacy drug review.
-There was a recommendation documented on the 12/29/25 pharmacy drug review for Resident #3 that was completed.

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C 375	Continued From page 21 Refer to the interview with the Administrator on 02/27/26 at 10:05am. Refer to the interview with the contracted pharmacy provider registered nurse (RN) on 02/27/26 at 10:11am. _____ Interview with the Administrator on 02/27/26 at 10:05am revealed: -The contracted provider pharmacy registered nurse (RN) conducted the pharmacy reviews at the facility. -The RN kept up with the due dates for the facility pharmacy reviews. -The RN called or sent a message to the Administrator to advise her of when she (RN) would be at the facility to complete the pharmacy reviews. -Based on the documented pharmacy reviews in the resident' records, the pharmacy reviews had not been completed quarterly. -She did not have any additional pharmacy reviews for 03/21/25 through 12/29/25 other than the documented reviews in the resident's records. -She was aware pharmacy reviews were supposed to be completed quarterly. -She did not review the RN's pharmacy review notes documented in the resident's records. -Once the pharmacy RN completed the pharmacy reviews, she would tell the Administrator what needed to be corrected. Telephone interview with the contracted pharmacy provider registered nurse (RN) on 02/27/26 at 10:11am revealed: -She completed the pharmacy drug reviews at the facility. -She was required to complete the drug reviews every three months. -In 2025, the drug reviews were "kind of spotty".	C 375		

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C 375	Continued From page 22 -She did not have a reason the pharmacy drug reviews were not completed quarterly and did not know if there was a timing issue relative to the 5-month timeframe between the 07/23/25 and 12/29/25 pharmacy drugs reviews completed. -She sent a message to the Administrator with any recommendations based on her drug review and there was typically no issue with the follow up of recommendations. -She thought it would be helpful if the facility would contact her the month before the due date for the next pharmacy drug review.	C 375		
C 443	10A NCAC 13G .1212 Record of Staff Qualifications 10A NCAC 13G .1212 RECORD OF STAFF QUALIFICATIONS A family care home shall maintain records of staff qulaifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure records of staff qualifications were maintained in the facility for 2 of 2 staff (Staff A, Staff B). The findings are:	C 443		

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C 443	Continued From page 23 Interview with the personal care aide/medication aide (PCA/MA) on 02/26/26 at 7:45am upon entrance to facility revealed: -She worked two weeks at the facility followed by one week off. -There was a second staff that relieved her when she was off for a week. Second interview with the PCA/MA on 02/26/26 at 9:18am revealed: -Three people worked at the facility, including the Administrator. -She could not find any staff records in the hall closet. -The Administrator had the staff records. -She just sent a text message to the Administrator and asked her to bring the staff records to the facility. Observation of the facility's Director on 02/26/26 at 12:02pm revealed he entered the facility and placed three notebooks on the desk. Interview with the facility's Director on 02/26/26 at 12:02pm revealed: -The three notebooks were staff records for facility employees. -Facility administration tried to make it a point to leave staff records at the facility. -He thought the Administrator had taken the staff records to update them. Interview with the Administrator on 02/27/26 at 8:15am revealed: -The staff records were at her home office on 02/26/26. -When she conducted a staff training, she took staff records with her so she could update the staff records.	C 443		

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C 443	Continued From page 24 -She had not returned the staff records to the facility. -She knew records of staff qualifications were to be maintained onsite at the facility.	C 443		