

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL058013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 03/24/2026
NAME OF PROVIDER OR SUPPLIER PRICE FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1385 BROWN ROAD JAMESVILLE, NC 27846			
(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 survey on March, 24, 2026.	C 000			
C 207	10A NCAC 13G .0702 (f) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination and Immunizations (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. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to clarify FL2 orders for 1 of 3 sampled residents (#2), pertaining to orders for a medication used to treat depression and a medication used to treat seizures and panic disorders. The findings are: Review of Resident #2's current FL-2 dated 12/04/25 revealed: -Diagnoses include cerebral palsy, hyperlipidemia, depression, developmental disability, and allergies. -There was an order for Seroquel (Seroquel is the	C 207	IN ORDER TO CORRECT C207 DEFICIENCY 10A NCAC 13G.0702 (f) Tuberculosis Test and Medical Examination; ADMINISTRATOR CONTACTED RES. #2 MENTAL HEALTH PROVIDER 4/6/26 AND OBTAINED CURRENT ORDER ON FILE AS TO MATCH WHAT PHARMACY HAS BEEN SENDING AND WHAT FACILITY HAS BEEN DISPENSING. ADMINISTRATOR HAD STAFF MEETING REGARDING CHANGES IN DOTORS ORDERS AND THE NEED FOR ACCURATE DOCUMENTATION. ADMINISTRATION WILL REVIEW RESIDENTS CHARTS PRIORS TO FL-2 COMPLETION AND ASK SIC OR LPN TO DOUBLE CHECK FL-2 FOR ACCURACY. THIS IS TO HELP PREVENT SIMILAR DEFICIENCIES IN THE FUTURE.	4/8/26 4/7/26	

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

TITLE

(X6) DATE

STATE FORM

6899

SW6001

Kathleen A Perry Administrator
4.9.26

If continuation sheet 1 of 8

Reviewed and Acknowledged

MW

05/04/26

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C 207	Continued From page 1 brand name for quetiapine, an antipsychotic that treats schizophrenia and bi-polar disorder, and depression) 400mg, take one and a half tablets at bedtime. -There was an order for Klonopin (Klonopin is the brand name for clonazepam, a medication used to treat seizures and panic disorders) 1mg, take one tablet three times daily. a. Review of Resident #2's signed physician order sheets dated 01/31/25 revealed an order for quetiapine fumarate 400mg, take one tablet every day at bedtime. Observations of Resident #2's medications on hand on 03/24/26 at 2:02pm revealed a bubble package labeled with Resident #2's name for quetiapine fumarate 400mg, take one tablet everyday at bedtime, dispensed on 03/04/26 for a quantity of 31, with 11 tablets remaining. Review of Resident #2's January 2026 medication administration record (MAR) revealed: -There was an entry for quetiapine fumarate 400mg, take one tablet every day at bedtime, scheduled for 8:00pm. -Quetiapine fumarate 400mg, one tablet was documented as administered at 8:00pm on 01/01/26 to 01/31/26. Review of Resident #2's February 2026 MAR revealed: -There was an entry for quetiapine fumarate 400mg, take one tablet every day at bedtime, scheduled for 8:00pm. -Quetiapine fumarate 400mg, one tablet was documented as administered at 8:00pm on 02/01/26 to 02/28/26. Review of Resident #2's March 2026 MAR	C 207			

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C 207	Continued From page 2 revealed: -There was an entry for quetiapine fumarate 400mg, take one tablet every day at bedtime, scheduled for 8:00pm. -Quetiapine fumarate 400mg, one tablet was documented as administered at 8:00pm on 03/01/26 to 03/23/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 03/24/26 at 2:32pm revealed: -An order for quetiapine 400mg, take one tablet daily at bedtime was originally received for Resident #2 on 07/18/24. -The most recent order received for Resident #2's quetiapine fumarate 400mg was received on 12/05/25, to take one tablet everyday at bedtime. b. Review of Resident #2's signed physicians order sheet dated 01/31/25 revealed an order for clonazepam (used to treat seizures and panic disorders) 1mg, take a half of a tablet (0.5mg) three times a day. Observations of Resident #2 medications on hand on 03/24/26 at 11:17am revealed a bubble package labeled with Resident #2's name for clonazepam 1mg, take a half of a tablet (0.5mg) three times a day, dispensed on 03/02/26 for a quantity of 45 tablets (90 half tablets), with 35 half tablets remaining. Review of Resident #2's January 2026 medication administration record (MAR) revealed: -There was an entry for clonazepam 1mg, take one half of a tablet (0.5mg) three times a day, scheduled at 8:00am, 2:00pm and 6:00pm. -Clonazepam 1mg, one half tablet (0.5mg) was documented as administered at 8:00am, 2:00pm and 6:00pm on 01/01/26 to 01/31/26.	C 207		

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C 207	Continued From page 3 Review of Resident #2's February 2026 MAR revealed: -There was an entry for clonazepam 1mg, take one half of a tablet (0.5mg) three times a day, scheduled at 8:00am, 2:00pm and 6:00pm. -Clonazepam 1mg, one half tablet (0.5mg) was documented as administered at 8:00am, 2:00pm and 6:00pm on 02/01/26 to 02/28/26. Review of Resident #2's March 2026 MAR revealed: -There was an entry for clonazepam 1mg, take one half of a tablet (0.5mg) three times a day, scheduled at 8:00am, 2:00pm and 6:00pm. -Clonazepam 1mg, one half tablet (0.5mg) was documented as administered at 8:00am on 03/01/26 to 03/24/26. -Clonazepam 1mg, one half tablet (0.5mg) was documented as administered at 2:00pm and 6:00pm on 03/01/26 to 03/23/26. Telephone interview with a pharmacist with the facility's contracted pharmacy on 03/24/26 at 2:32pm revealed: -An order for Resident #2's clonazepam 1mg, take a half of a tablet (0.5mg) three times daily was originally received on 07/14/24. -The most recent order received for Resident #2's clonazepam 1mg was received on 12/05/25, to take a half tablet (0.5mg) three times per day. Interview with the Administrator on 03/24/26 at 4:29pm revealed: -She was responsible for completing the residents' FL2 forms and sending them to the provider for signature. -When she completed a resident's FL2, she pulled their medication administration record, and medication orders and recorded the medications on the FL2 form.	C 207		

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C 207	Continued From page 4 -She had not noticed that the dosages documented for Resident #2's scheduled clonazepam and quetiapine were incorrect on Resident #2's FL2. -It was her responsibility to review each resident's FL2 form for accuracy. Attempted telephone interview with Resident #2's primary care provider (PCP) on 03/24/26 at 3:23pm was unsuccessful. Attempted telephone interview with Resident #2's behavioral health provider on 03/24/26 at 2:28pm was unsuccessful.	C 207		
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 ensure the acute healthcare needs for 1 of 3 sampled residents (#1) were met by failing to contact the resident's general surgeon regarding dressing changes for an open wound. The findings are: Review of Resident #1's current FL-2 dated 11/18/25 revealed diagnoses included edema, obstructive sleep apnea, depression, and schizoaffective disorder. Observation of Resident #1 on 03/24/26 at 8:16am revealed:	C 246	IN ORDER TO CORRECT C 246 DEFICIENCY 10A NCAC 13G .0902 (b) Health Care ADMINISTRATOR CONTACTED RES #1 GENERAL SURGEON 4/2/26 @ 10:15 am REGARDING AN ORDER FOR HER WOUND. FACILITY REC'D ORDER @ 10:38 am, THE SAME DAY. ADMINISTRATOR CONTACTED LHPS-RN WHO WILL VISIT, GO OVER ORDER AND WOUND CARE WITH STAFF. ADMINISTRATOR HAD STAFF MEETING REGARDING THE NEED TO MAKE SURE ALL ORDERS ARE REQUESTED AND FULLY DOCUMENTED. ADMINISTRATOR WILL REVIEW CHARTS MONTHLY FOR ANY CHANGES AND MAKE SURE ALL CHANGES (IF ANY) ARE DOCUMENTED. TO PREVENT SIMILAR DEFICIENCIES IN THE FUTURE.	4/2/26 4/10/26 4/7/26

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C 246	Continued From page 5 -Resident #1 was lying in bed. -The Administrator told Resident #1 that she was going to change her dressing. -Resident #1 raised her top to reveal a dry dressing to her right side. -The Administrator donned gloves and removed the existing dressing and disposed of it. -Resident #1 had about a one-and-a-half-inch oblong open wound to the right rib area, the wound appeared dry and free of redness or drainage. -The Administrator sprayed Resident #1's wound with an over-the-counter antiseptic cleansing spray and patted it dry with a new clean gauze. -The Administrator covered Resident #1's wound with several new clean gauze pads and secured the gauze pads with paper tape. -The Administrator removed her gloves, invited Resident #1 to breakfast, and proceeded to the kitchen sink to wash her hands. Interview with Resident #1 on 03/24/26 at 3:23pm revealed: -The Administrator changed her dressing twice daily. -When the Administrator was off, the Supervisor-in-Charge changed her dressing. Interview with the Administrator on 03/24/26 at 7:58am revealed: -Resident #1 had a gall bladder abscess a couple of years ago and had to have two drains placed. -After the drains were removed, one of Resident #1's drain sites from the gall bladder abscess never healed. -Resident #1 was previously treated at a wound clinic for the non-healed drain site but was now followed by her general surgeon every 4 to 6 months. -Resident #1 received dressing changes twice a	C 246			

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C 246	Continued From page 6 day. -She planned to change Resident #1's dressing and then bring her out to breakfast. Second interview with the Administrator on 03/24/26 at 11:40am revealed: -Resident #1's general surgeon had not given any orders for Resident #1's wound as far as dressing changes. -Resident #1's general surgeon told her at each of the resident's visits that her wound looked good and to "keep doing what you are doing". -The facility's Licensed Practical Nurse (LPN) advised her as to what type dressing Resident #1's wound required. -She did not know that an order was required for Resident #1 to have dressing changes. Review of Resident #1's record on 03/24/26 revealed there was no order for Resident #1 to have dressing changes. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/24/26 at 2:32pm revealed there were no orders on file for Resident #1 for dressing changes. Telephone interview with the medical assistant at Resident #1's primary care provider's (PCP) on 03/24/26 at 3:42pm revealed: -Resident #1's PCP did not manage her right-side wound. -There were no orders on file for Resident #1 to have dressing changes. -There was no documentation their office had been contacted by facility staff regarding dressing changes for Resident #1. Telephone interview with a Registered Nurse (RN) at Resident #1's general surgeon's office on 03/24/26 at 3:05pm revealed:	C 246		

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C 246	Continued From page 7 -Resident #1 had a history of a chronic biliary fistula from the fundus of the gall bladder that had invaded the abdominal wall since 2023. -Resident #1 was seen in their office every 6 months, her last office visit was 12/11/25 and her next appointment with the general surgeon was 06/11/26. -Resident #1's last visit was 12/11/25 and her general surgeon noted her wound was well managed by the facility's Administrator. -There were no orders on file for Resident #1 to have dressing changes. -There was no documentation that facility staff had contacted their office regarding dressing changes for Resident #1. Third interview with the Administrator on 03/24/26 at 4:29pm revealed: -She had not considered that an order was needed for Resident #1 to have dressing changes. -She should have contacted Resident #1's general surgeon for orders regarding her wound and dressing changes. Attempted telephone interview with Resident #1's general surgeon on 03/24/26 at 3:05pm was unsuccessful.	C 246			