STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL081053	A. BUILDING: _____ B. WING _____	R 06/28/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LISA'S FAMILY CARE HOME # 2	141 FOX RUN FOREST CITY, NC 28043

(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 Rutherford County Department of Social Services conducted an annual and follow up survey on 06/28/19.	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 interviews and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to medications for schizophrenia, anxiety, depression, and insomnia. The findings are: Review of Resident #3's current FL2 dated 05/28/19 revealed diagnosis included insomnia, persistent tremors, and depressive disorder. a. Review of medication orders on the current FL2 dated 05/28/19 revealed: -A medication order for Latuda (antipsychotic medication) 80mg tablet. -There was no dose, route, or time listed for the latuda. Review of an FL2 for Resident #3 dated 02/08/19	C 330		

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revealed a medication order for Latuda 80mg tablet, 2 tablets every day.

Review of Resident #3's May 2019 Medication Administration Record (MAR) revealed:
-Latuda 80mg tablet, two tablets every morning with an administration time of 8:00am was listed on the MAR.
-The Latuda was documented as administered daily at 8:00am for May 2019.

Review of Resident #3's June 1 - 28, 2019 MAR revealed:
-Latuda 80mg tablet, two tablets every morning with an administration time of 8:00am was listed on the MAR.
-The Latuda was documented as administered daily at 8:00am for June 1 - 28, 2019.

Telephone interview with the Physcian's Nurse Practitioner (NP) for Resident #3 on 06/28/19 at 2:25pm revealed:
-The facility had just called today (06/28/19) to clarify the Latuda medication order from 05/28/19.
-There were no acute or long term risks to the Resident from not receiving the correct dose of Latuda.

Review of a clarification medication order dated 06/28/19 revealed an order for Latuda 80mg, give one tablet daily.

Refer to the interview with the Supervisor in Charge (SIC) on 06/28/19 at 9:19am.

Refer to the interview with the facility Manager on 06/28/19 at 9:45am.

Refer to the telephone interview with a representative from the facility's contracted

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pharmacy on 06/28/19 at 9:57am.

b. Review of medication orders on the current FL2 dated 05/28/19 revealed:
-A medication order for lorazepam (anti anxiety medication) 1mg tablet.
-There was no dose, route, or time listed for the lorazepam.

Review of an FL2 for Resident #3 dated 02/08/19 revealed a medication order for lorazepam 1mg tablet three times daily.

Review of Resident #3's May 2019 Medication Administration Record (MAR) revealed:
-Lorazepam 1mg tablet, one tablet three times daily with administration times of 8:00am, 4:00pm, and 8:00pm was listed on the MAR.
-The lorazepam was documented as administered daily at 8:00am, 4:00pm, and 8:00pm for May 2019.

Review of Resident #3's June 1 - 28, 2019 MAR revealed:
-Lorazepam 1mg tablet, one tablet three times daily with administration times of 8:00am, 4:00pm, and 8:00pm was listed on the MAR.
-The lorazepam was documented as administered daily at 8:00am, 4:00pm, and 8:00pm June 1 - 27, and at 8:00am June 28.

Telephone interview with the Physician's Nurse Practitioner (NP) for Resident #3 on 06/28/19 at 2:25pm revealed:
-The facility had just called today (06/28/19) to clarify the lorazepam medication order from 05/28/19.
-Receiving the incorrect dose of lorazepam could cause drowsiness in Resident #3.
-There were no long term risks to Resident #3

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C 330	Continued From page 3 receiving the incorrect dose of lorazepam. Review of a clarification medication order dated 06/28/19 revealed an order for lorazepam 1mg daily. Refer to the interview with the Supervisor in Charge (SIC) on 06/28/19 at 9:19am. Refer to the interview with the facility Manager on 06/28/19 at 9:45am. Refer to the telephone interview with a representative from the facility's contracted pharmacy on 06/28/19 at 9:57am. c. Review of medication orders on the current FL2 dated 05/28/19 revealed: -A medication order for sertraline (antidepressant) 100mg tablet. -There was no dose, route, or time listed for sertraline. Review of an FL2 for Resident #3 dated 02/08/19 revealed a medication order for sertraline 100mg tablet, give 1 and 1/2 tablets daily at bedtime. Review of Resident #3's May 2019 Medication Administration Record (MAR) revealed: -Sertraline 100mg tablet, 1 and 1/2 tablets (150mg) every night at bedtime with an administration time of 8:00pm. -The sertraline was documented as administered daily at 8:00pm for May 2019. Review of Resident #3's June 1 - 28, 2019 MAR revealed: -Sertraline 100mg tablet, 1 and 1/2 tablets (150mg) every night at bedtime with an administration time of 8:00pm.	C 330		

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-The sertraline was documented as administered daily at 8:00pm for June 1 - 27.

Telephone interview with the Physician's Nurse Practitioner (NP) for Resident #3 on 06/28/19 at 2:25pm revealed:
-The facility had just called today (06/28/19) to clarify the sertraline medication order from 05/28/19.
-There were no long term risks to Resident #3 receiving the incorrect dose of sertraline.

Review of a clarification order dated 06/28/19 revealed an order for sertraline 100mg daily.

Refer to the interview with the Supervisor in Charge (SIC) on 06/28/19 at 9:19am.

Refer to the interview with the facility Manager on 06/28/19 at 9:45am.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 06/28/19 at 9:57am.

d. Review of medication orders on the current FL2 dated 05/28/19 revealed:
-A medication order for trazadone (antidepressant medication) 50mg tablet.
-There was no dose, route, or time listed for the trazadone.

Review of an FL2 for Resident #3 dated 02/08/19 revealed a medication order for trazadone 200mg everyday at bedtime.

Review of Resident #3's May 2019 Medication Administration Record (MAR) revealed:
-Trazadone 100mg tablet, take two tablets (200mg) every night at bedtime with an

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administration time of 8:00pm.
-The trazadone was documented as administered daily at 8:00pm for May 2019.

Review of Resident #3's June 1 - 28, 2019 MAR revealed:
-Trazadone 100mg tablet, take two tablets (200mg) every night at bedtime with an administration time of 8:00pm.
-The trazadone was documented as administered daily at 8:00pm for June 1 - 27.

Telephone interview with the Physician's Nurse Practitioner (NP) for Resident #3 on 06/28/19 at 2:25pm revealed:
-The facility had just called today (06/28/19) to clarify the trazadone medication order from 05/28/19.
-There were no long term risks to Resident #3 receiving the incorrect dose of trazadone.

Review of a clarification order dated 06/28/19 revealed an order for trazadone 50mg at bedtime as needed.

Refer to the interview with the Supervisor in Charge (SIC) on 06/28/19 at 9:19am.

Refer to the interview with the facility Manager on 06/28/19 at 9:45am.

Refer to the telephone interview with a representative from the facility's contracted pharmacy on 06/28/19 at 9:57am.

Interview with the Supervisor in Charge (SIC) on 06/28/19 at 9:19am revealed:
-The facility manager takes new FL2s to the physician for a signature.
-The physician's office was responsible for faxing

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C 330	Continued From page 6 the FL2s to the pharmacy. Interview with the facility Manager on 06/28/19 at 9:45am revealed: -He was responsible for reviewing the FL2s for accuracy. -The physican would "write in the meds" and sign. -The Manager was responsible for faxing the completed FL2s to the pharmacy. -He had "missed" faxing the FL2 to the pharmacy. Telephone interview with a representative from the facility's contracted pharmacy on 06/28/19 at 9:57am revealed: -The last FL2 the pharmacy had received for Resident #3 was dated 02/18/19. -They had not received the FL2 dated 05/28/19. -The pharmacy consultant had requested on 06/24/19 the most current FL2 to be faxed to the pharmacy. -The pharmacy had not received the fax.	C 330		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening	C992		

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C992	Continued From page 7 of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 2 sampled staff (Staff A) had completed an examination and screening for the presence of controlled substances upon hire. The findings are: Review of Staff A's personnel record revealed: -She was hired as a Medication Aide (MA) on 03/06/19. -There was no documentation of a controlled substance examination and screening in her personnel record. Interview with the facility Manager on 06/28/19 at	C992		

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C992	Continued From page 8 3:00pm revealed: -He was responsible for ensuring controlled substance screens were completed for new employees. -He knew he had completed one for Staff A upon hire. -He "thought" the documentation was in Staff A's personnel record. Interview with Staff A on 06/28/19 at 3:32pm revealed: -She knew she had completed a controlled substance screen upon hire. -She did not know where the paperwork was.	C992		