STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRY CARE HOME	2446 CHERRY GROVE ROAD YANCEYVILLE, NC 27379

(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 12/20/22.	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 ensure the primary care provider (PCP) notification for 1 of 1 resident (#1) who refused to wear his compression stockings. The findings are: Review of Resident #1's current FL-2 dated 02/04/22 revealed: -Diagnoses included sepsis, lymphedema, pleural effusion, pericarditis with effusion, schizoaffective disorder, depression, chronic diastolic heart failure, human immunosuppressant virus, hypertension, diabetes, focal segmental glomerulosclerosis, monoclonal gammopathy of undetermined significance. -There was an order for compression stockings on in the am and off in the pm. Observation of Resident #1 on 12/20/22 at 9:27am revealed: -He was sitting in his recliner chair with his legs elevated. -He was wearing a pair of soft white socks that were bunched up around his ankle area. -When he pulled his socks down, the socks had caused indentions on both legs.	C 246		

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	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

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C 246	Continued From page 1 Interview with Resident #1 on 12/20/22 at 9:27am revealed: -He had not worn compression stockings in about 7-8 months. -When he wore the compression stockings the stockings squeezed his legs so tight, they hurt. Second interview with Resident #1 on 12/20/22 at 3:43pm revealed: -He had last seen his PCP about 4-6 months ago. -His left leg had been swelling. -He did not know if his PCP knew he was not wearing his compression stockings or not. -His PCP told him to keep his legs elevated so he was doing that all of the time. -He had purchased two pairs of compression stockings, but he thought he had thrown one pair of them away. -He had white socks he wore, and he also had black diabetic socks. Observation of Resident #1's sock drawer on 12/20/22 at 4:38pm revealed: -He had multiple pairs of soft white socks. -He had multiple pairs of soft black socks. -He had one pair of compression socks that were in their original package and had not been worn. -The second pair of compression socks were not seen in the drawer. Review of Resident #1's October 2022 medication administration record (MAR) revealed: -There was an entry for compression stockings with a scheduled administration time of 8:00am and removal time of 8:00pm. -There was documentation that Resident #1's compression stockings had been applied and removed daily from 10/01/22-10/31/22.	C 246		

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	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

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C 246	Continued From page 2	C 246		

Review of Resident #1's November 2022 MAR for revealed:
-There was an entry for compression stockings with a scheduled administration time of 8:00am and removal time of 8:00pm.
-There was documentation that Resident #1's compression stockings had been applied and removed daily from 11/01/22-11/20/22.

Review of Resident #1's December 2022 MAR for 12/01/22-12/20/22 revealed:
-There was an entry for compression stockings with a scheduled administration time of 8:00am and removal time of 8:00pm.
-There was documentation that Resident #1's compression stockings had been applied and removed daily from 12/01/22-12/20/22.

Interview with the medication aide (MA) on 12/20/22 at 8:43am revealed:
-She knew Resident #1 was not wearing compression stockings.
-She put Resident #1's compression stockings on every morning, "I put them on, and he took them off."
-She did not know if Resident #1's PCP knew he was not wearing compression stockings.
-Resident #1 wore his black socks to his appointments.
-She put black socks on Resident #1 every day.
-She documented on Resident #1's MAR because she thought the black socks were compression stockings, she had put on him.
-She knew compression stockings were "those that are hard to get on."
-She had not asked anyone about the entry on the MAR for compression stockings.

Telephone interview with the Owner/Manager on 12/20/22 at 5:00pm revealed:

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C 246	Continued From page 3 -She thought Resident #1 had compression stockings. -She usually measured residents for compression stockings and would send the measurements to the pharmacy. -She could not recall if she had done this for Resident #1 because he was peculiar about purchases and liked to buy things for himself. -The MA was responsible for notifying the PCP if Resident #1 was not wearing his compression stockings. -The MA had not told her Resident #1 was not wearing his compression stockings. Telephone interview with Resident #1's PCP on 12/21/22 at 8:40am revealed: -She had ordered compression stockings for Resident #1 because of swelling in his lower legs. -She wanted Resident #1 to wear compression stockings to reduce swelling. -If Resident #1 did not wear the compression stockings the swelling would not improve, which could cause pain, and decreased ability to ambulate. -Ongoing fluid build-up could affect Resident #1's heart and kidneys. -She had not been notified Resident #1 was not wearing his compression stockings. -She expected Resident # to wear compression stockings and she would follow up to make sure Resident #1 was measured for compression stockings. Attempted interview with the Administrator on 12/20/22 at 5:00pm was unsuccessful.	C 246		
C 273	10A NCAC 13G .0904(d)(3)(A) Nutrition and Food Service	C 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRY CARE HOME	2446 CHERRY GROVE ROAD YANCEYVILLE, NC 27379

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C 273	Continued From page 4 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 8 ounces of milk was served to the residents twice daily. The findings are: Observation of the refrigerator on 12/20/22 at 8:31am revealed: -There was an opened gallon of milk with approximately one cup of milk remaining. -There was no other milk in the refrigerator. Observation of the breakfast meal service on 12/20/22 at 8:17am revealed the residents were served coffee and juice with their meals. Observation of the lunch meal on 12/20/22 at 12:15pm revealed the residents were served water and tea with their meals; milk was not offered. Interview with two residents on 12/20/22 between 8:38am-9:00am revealed: -The only time they were given milk was when they had cereal to eat. -They both liked milk and would drink it if it was	C 273		

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	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 273	Continued From page 5 offered. Interview with a third resident on 12/20/22 at 8:43am revealed: -He purchased his own milk and kept it in a refrigerator in his room. -The facility never offered milk to drink. -The facility only provided milk on the days they had cereal. Interview with a fourth resident on 12/20/22 at 8:48am revealed: -He liked milk to drink. -He purchased his own milk. -He would drink milk provided by the facility if they offered milk to drink, but they did not. Interview with the Supervisor-in-Charge (SIC) on 12/20/22 at 2:04pm revealed: -She gave milk to the residents when they had cereal for breakfast. -The residents did not want milk to drink. -She had not asked the residents if they wanted milk to drink. Interview with the facility owner/Manager on 12/20/22 at 5:00pm revealed: -She expected milk to be offered to the residents twice daily. -The SIC notified her when the milk was low. -She had not been notified there was only one cup of milk in the refrigerator. -She knew two residents purchased their own milk; it was their right to purchase what they wanted. -She thought the SIC was providing milk for the residents to drink. Attempted interview with the Administrator on 12/20/22 at 5:00pm was unsuccessful.	C 273		

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C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to develop and implement an activity program that promoted active involvement for 5 of 5 sampled residents who resided in the facility. The findings are: Observation of the December 2022 activity calendar posted in the kitchen area on 12/20/22 at 8:23am revealed: -There were 4 hours of activities scheduled the week of 04/01/21 through 04/03/21. -There were 12 hours of activities scheduled for each week between 04/04/21 and 04/30/21. -On each Sunday, Gospel Music was scheduled from 7:00am to 12:00pm. -On each Monday, Bible Study was scheduled from 9:30am-11:30am. -On each Tuesday, Bingo was scheduled from 1:00pm to 4:00pm. -On each Wednesday, Current Events was scheduled from 2:00pm to 4:00pm. -On each Thursday, Current Events was scheduled from 2:00pm to 4:00pm. -On each Friday, TGIF was scheduled from 8:00pm to 10:00pm. -On each Saturday, "On your own" was scheduled from 1:00pm-3:00pm.	C 288		

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	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

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C 288	Continued From page 7 Observation of the residents on 12/20/22 between 8:15am and 5:00pm revealed: -Residents spent most of the day in their rooms. -Residents went out to smoke. -There was music playing in the kitchen area through the day. Interview with 4 residents on 12/20/22 between 8:38am-9:00am revealed: -There were no activities offered in the facility. -One resident stated activities were never offered but they wish they were. -Another resident stated the facility never offered activities; he liked to play bingo. -A third resident stated he liked to play Bingo, and he liked Bible study. -A fourth resident stated that would like "anything" to do. Interview with a fifth resident on 12/20/22 at 8:56am revealed: -There were no activities offered in the facility. -There were a lot of residents who had anxiety and depression. -If the facility offered more for the residents to do, the residents would probably have less anxiety. Second interview with a resident on 12/20/22 at 3:02pm revealed: -Two residents played bingo with the Supervisor-in-Charge (SIC) today, 12/20/22. -They only played one round and the SIC stopped and said they would play again later. -They did not have any prizes, but it was still fun. -It was the first time they had played bingo in a long time. Interview with the SIC on 12/20/22 at 2:04pm revealed: -The residents did not want to participate in	C 288		

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C 288	Continued From page 8 activities. -The residents only wanted to watch television. -Bible study had stopped because of COVID-19. -She played cards with one resident, "it had been a while." -They did not have prizes for bingo. Interview with the facility owner/Manager on 12/20/22 at 5:00pm revealed: -She was responsible for the development and implementation of the activities program. -She prepared the activities calendar one month in advance. -Churches had not started going back into facilities since COVID-19. -She usually took 1-2 residents out at a time each month. -She had hired a named employee to help with activities at the facility. -The named employee was at the facility one day last week. -The days the named employee was not at the facility, the SIC was responsible for the activities. Attempted interview with the Administrator on 12/20/22 at 5:00pm was unsuccessful.	C 288		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's	C 341		

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	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

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C 341	Continued From page 9 medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed residents taking their medications for 2 of 5 residents sampled (#1, #2). The findings are: Observation of the dining room table on 12/20/22 at 8:15am revealed: -There were four residents sitting at the table. -Each resident had a pill cup sitting at their place setting. -One place setting had a pill cup with medications, but the resident had not come to the table. -Another medication cup contained medications, and an inhaler was lying on the table at the place setting. -Three of the residents had taken their medications. -There was no staff in the room during the observation. Observation of the kitchen counter on 12/20/22 from 8:25am-8:32am revealed the resident's inhaler was unattended on the counter with no staff in the room. Interview with five residents on 12/20/22 from 8:15am-9:30am revealed: -Their medications were always in medication cups at the dining room table. -The medication aide (MA) was sometimes in the room when they took their medications, and	C 341		

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	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 341	Continued From page 10	C 341		

sometimes the MA was not in the room.

1. Review of Resident #1's current FL-2 dated 02/04/22 revealed diagnoses included sepsis, lymphedema, pleural effusion, pericarditis with effusion, schizoaffective disorder, depression, chronic diastolic heart failure, human immunosuppressant virus, hypertension, diabetes, focal segmental glomerulosclerosis, and monoclonal gammopathy of undetermined significance.

Observation of Resident #1's medications at the table on 12/20/22 at 8:15am revealed:
-There were 18 tablets in a medication cup and an inhaler on the dining room table at his place setting.
-Resident #1 poured the 18 tablets onto the dining room table.
-There was no staff present when he began taking his medications.

Review of Resident #1's December 2022 medication administration record (MAR) for 12/16/22-12/20/22 at 8:34am revealed:
-There were entries for 18 medications with a scheduled administration time of 8:00am.
-There was no documentation the 18 medications had been administered since 12/16/22.

Second review of Resident #1's December 2022 MAR for 12/16/22-12/20/22 at 11:49am revealed:
-There were entries for 18 medications with a scheduled administration time of 8:00am.
-There was documentation 18 medications had been administered daily from 12/17/22-12/20/22.

Interview with Resident #1 on 12/20/22 at 8:38am revealed:
-He took his medications at the dining room table

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

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C 341	Continued From page 11	C 341		

every morning.
-He knew what some of his medications were but not all of them.
-He took whatever the medication aide (MA) put in his medication cup.

Attempted interview with the Administrator on 12/20/22 at 5:00pm was unsuccessful.

Refer to the interview with the MA on 12/20/22 at 8:43am.

Refer to the second interview with the MA on 12/20/22 at 4:21pm.

Refer to the telephone interview with the owner/manager on 12/2/22 at 5:00am.

2. Review of #2's current FL-2 dated 12/15/22 revealed diagnoses included schizoaffective disorder, post-traumatic stress disorder, hypertension, vitamin D deficiency, diabetes and hypolipidemia.

Observation of Resident #2's medications at the table on 12/20/22 at 8:15am revealed:
-There were 7 tablets in a medication cup on the dining room table at his place setting; he was in his room with the door closed.
-There was no staff present when the medications were on the table.

Review of Resident #2's December 2022 eMAR for 12/20/22 at 8:34am revealed:
-There were entries for 5 medications, a total of 7 tablets, scheduled to be administered at 8:00am.
-There was documentation 5 medications had been administered on 12/20/22.

Interview with Resident #2 on 12/20/22 at 8:56am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 341	Continued From page 12 revealed: -He took his medication at the dining room table in the mornings. -He took whatever the MA put in his medication cup. Attempted interview with the Administrator on 12/20/22 at 5:00pm was unsuccessful. Refer to the interview with the MA on 12/20/22 at 8:43am. Refer to the second interview with the MA on 12/20/22 at 4:21pm. Refer to the telephone interview with the owner/manager on 12/2/22 at 5:00am. _____ Interview with the MA on 12/20/22 at 8:43am revealed: -She put the residents' medications in a cup and placed the cup at the residents' plate on the dining room table. -She always put the medications on the table and usually stayed in the room with the residents. -She did not know why she did not stay in the room today, 12/20/22, because "I did not." Second interview with the MA on 12/20/22 at 4:21pm revealed she normally watched the residents take their medication but did not today, 12/20/22, because she had to go to the restroom. Telephone interview with the Owner/Manager on 12/20/22 at 5:00pm revealed: -She did not know the MA was putting the residents' medications in cups and placing the cup at the residents' plates. -She expected the MA to pull the residents' medications individually, administer the	C 341		

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	FCL017009	A. BUILDING: _____ B. WING _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRY CARE HOME	2446 CHERRY GROVE ROAD YANCEYVILLE, NC 27379

(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 341	Continued From page 13 medication, watch the resident take the medication and then document the medication had been taken. -She had trained all the MAs to not put the medication cups at the table.	C 341		