

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/15/2023
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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 a Follow-Up survey on August 15, 2023.	C 000		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuated the facility without verbal prompting resulting in 6 of 6 residents (#1, #2, #3, #4, #5 and #6) who did not respond to the fire drill. The findings are: Review of the facility's current license effective 01/01/23 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire rehearsal schedule revealed:	C 100		

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

TITLE

(X6) DATE

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C 100	Continued From page 1 -The fire rehearsal/drill schedule form was a prepopulated form with the description of fire rehearsal as a fire alarm. All residents were instructed to exit their nearest exit. Staff members checked each room and common area with fire extinguishers in hand. Residents were instructed to meet at the well in the yard in front of the facility. -The form had an area to write in the time of the evacuation. -On 01/05/23 at 10:00am, the total time of the evacuation was 3 minutes. -On 02/16/23 at 12:00pm, the total time of the evacuation was 3 minutes. -On 03/10/23 at 2:00pm, the total time of the evacuation was 3 minutes. -On 04/20/23 at 7:00pm, the total time of the evacuation was 3 minutes. -On 05/02/23 at 2:00pm, the total time of the evacuation was 2 minutes. -On 06/03/23 at 9:20am, the total time of the evacuation was 3 minutes. -On 07/20/23 at 10:00am, the total time of the evacuation was 3 minutes. -On 08/08/23 at 10:30am, the total time of the evacuation was 3 minutes. -There was no documentation related to how many residents were present at each fire rehearsal. Confidential interviews with three residents revealed: -They did not have fire drills every month. -One resident did not recall the last time they had a fire drill. -Another resident stated they had a fire drill last week; she did not recall the date. -A third resident stated it had been months since they had a fire drill. -The staff always told them to exit the facility	C 100		

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C 100	Continued From page 2 when they had a fire drill. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -The last time a fire drill was conducted at the facility was last week, 08/08/23, when an inspector was at the facility. -She did not conduct fire drills at the facility. -The Administrators usually conducted fire drills. -There had not been any fire drills conducted when she was working at the facility, but she had only been back working at the facility since May of 2023. Interview with the Assistant Administrator on 08/15/23 at 4:38pm revealed: -He had conducted fire drills at the facility. -The last fire drill he conducted was earlier this year, and he did not recall the date. -When he conducted a fire drill, none of the residents exited the facility and he had to tell them when they heard the fire drill they were to go outside and head toward the flagpole. -All the residents were capable physically and mentally to respond to fire drills, they just did not. 1. Review of Resident #1's current FL-2 dated 07/14/23 revealed: -Diagnoses included Schizophrenia disorder bipolar type, dependent personality disorder, hypertension, obesity, and diabetes. -The resident was semi-ambulatory. -The resident required assistance with bathing and dressing. -The resident was oriented. Review of Resident #1's Resident Register revealed an admission date of 03/15/17. Review of Resident #1's care plan dated 10/25/22	C 100		

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C 100	Continued From page 3 revealed: -The resident was ambulatory with a walker. -The resident required supervision with eating and toileting, -The resident required limited assistance with ambulation, bathing, dressing, grooming, and transfers. -The resident's vision and hearing were adequate. -The resident was forgetful and needed reminders. Observation of the facility on 08/15/23 at various times between 8:00am-6:00pm revealed: -Resident #1 went in and out of the facility using her walker. -Resident #1 spent most of her day outside in the smoking area or laying in her bed. -The resident could get up from the dining room chair, her bed, and the chairs outside of the facility without assistance. Observation of the facility on 08/15/23 from 4:11pm-4:13pm: -The Administrator activated the fire alarm at 4:11pm. -Resident #1 was laying on her bed with her eyes closed. -The door to her bedroom was open. -The fire alarm could be heard in the resident's room Interview with Resident #1 on 08/15/23 at 6:03pm revealed: -She did not hear the fire alarm. -If she had heard the fire alarm, she would have exited the facility. 2. Review of Resident #2's current FL-2 dated 07/14/23 revealed:	C 100		

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C 100	Continued From page 4 -Diagnoses included catatonia schizophrenia, diabetes mellitus, hypertension, and mixed hyperlipidemia. -The resident was ambulatory. -The resident was oriented. Review of Resident #2's Resident Register revealed an admission date of 04/26/22. Review of Resident #2's care plan dated 07/25/23 revealed: -The resident was ambulatory. -The resident required supervision with eating and toileting, -The resident required limited assistance with ambulation, bathing, dressing, grooming, and transfers. -The resident's vision was adequate. -There was no documentation about the residents hearing. -The resident was oriented. Observation of the facility on 08/15/23 at various times between 8:00am-6:00pm revealed: -Resident #2 ambulated without assistance. -Resident #2 spent her day in the living room watching television or in her room reading. Observation of the facility on 08/15/23 from 4:11pm-4:13pm: -The Administrator activated the fire alarm at 4:11pm. -Resident #2 was sitting on the couch in the living room watching television with another resident. -She did not move from the couch when the fire alarm was sounding. Interview with Resident #2 on 08/15/23 at 4:12pm revealed: -She heard a noise coming from the kitchen; she	C 100		

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C 100	Continued From page 5 thought it might be the smoke alarm. -She thought she was supposed to exit the facility when she heard the smoke alarm. Observation of Resident #2 on 08/15/23 at 4:12pm revealed she exited the facility after being asked about the fire alarm. 3. Review of Resident #3's current FL-2 dated 07/14/23 revealed: -Diagnoses included moderate intellectual disability, severe bipolar affective disorder, aggression, and acute renal failure. -The resident was ambulatory. -The resident was verbally abusive. Review of Resident #3's Resident Register revealed an admission date of 06/01/21. Review of Resident #3's care plan dated 07/26/23 revealed: -The resident was ambulatory. -The resident required supervision with eating and toileting, -The resident required limited assistance with ambulation, bathing, dressing, grooming, and transfers. -The resident's vision was adequate and she heard loud sounds and voices. -The resident's memory was adequate. Observation of the facility on 08/15/23 at various times between 8:00am-8:30am revealed: -Resident #3 ambulated with a walker. -Resident #3 left the facility to go to a day program. Observation of the facility on 08/15/23 from 4:11pm-4:13pm: -The Administrator activated the fire alarm at	C 100		

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C 100	Continued From page 6 4:11pm. -Resident #3 was sitting in a chair in the living room watching television with another resident. -Resident #3 did not move from the chair when the fire alarm was sounding. Observation of Resident #3 on 08/15/23 at 4:12pm revealed she exited the facility after another resident in the room was asked about the fire alarm. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable. 4. Review of Resident #4's current FL-2 dated 12/21/22 revealed: -Diagnoses included schizophrenia, obsessive-compulsive disorder, and overactive bladder. -The resident was ambulatory. -The resident was intermittently disoriented, wandered, and injurious to self and others. Review of Resident #4's Resident Register revealed an admission date of 12/09/21. Review of Resident #4's care plan dated 10/25/22 revealed: -The resident was ambulatory. -The resident required supervision with eating and toileting, -The resident required limited assistance with ambulation, bathing, dressing, grooming, and transfers. -The resident's vision and hearing were adequate. -The resident's memory was adequate. Observation of the facility on 08/15/23 at various	C 100		

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C 100	Continued From page 7 times between 8:00am-8:30am revealed: -Resident #4 ambulated independently. -Resident #4 left the facility to go to a day program. Observation of the facility on 08/15/23 from 4:11pm-4:13pm: -The Administrator activated the fire alarm at 4:11pm. -Resident #4 was laying on her bed and was wearing headphones. -The door to her bedroom was open. -The fire alarm could be heard in the resident's room Interview with Resident #4 on 04/18/23 at 6:05pm revealed: -She did not hear the fire alarm. -If she heard the fire alarm, she knew to go outside of the facility. 5. Review of Resident #5's current FL-2 dated 07/14/23 revealed: -Diagnoses included schizophrenia, schizoaffective disorder, narcissistic personality disorder, and osteoarthritis of the right knee. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #5's Resident Register revealed an admission date of 04/06/16. Review of Resident #5's care plan dated 06/15/22 revealed: -The resident was ambulatory. -The resident required supervision with eating and toileting, -The resident required limited assistance with ambulation, bathing, dressing, grooming, and transfers.	C 100		

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C 100	Continued From page 8 -The resident's vision and hearing were adequate. -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. Observation of the facility on 08/15/23 at various times between 8:00am-6:00pm revealed: -Resident #5 was ambulatory. -Resident #5 spent most of her day outside in the smoking area or laying in her bed. Observation of the facility on 08/15/23 from 4:11pm-4:13pm: -The Administrator activated the fire alarm at 4:11pm. -Resident #5 was laying in her bed with her eyes open. -The door to her bedroom was open and the fire alarm could be heard in the resident's room. Interview with Resident #5's on 08/15/23 at 4:13pm revealed: -She knew what the alarm sound was. -She knew what to do when she heard the alarm. -She became agitated and refused to answer additional questions. -Resident #5 did not get up from her bed. 6. Review of Resident #6's current FL-2 dated 11/16/22 revealed: -Diagnoses included mild intellectual disability, major depression, and hyponatremia, -The resident was ambulatory. -The resident was oriented. -The resident was injurious to self. Review of Resident #6's Resident Register revealed an admission date of 04/04/22.	C 100		

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C 100	Continued From page 9 Review of Resident #6's care plan dated 06/15/22 revealed: -The resident was ambulatory. -The resident required supervision with eating and toileting, -The resident required limited assistance with ambulation, bathing, dressing, grooming, and transfers. -The resident's vision and hearing were adequate. -The resident's memory was adequate Observation of the facility on 08/15/23 at various times between 8:00am-6:00pm revealed: -Resident #6 was ambulatory. -Resident #6 spent most of her day outside in the smoking area or sitting on her bed. Observation of the facility on 08/15/23 from 4:11pm-4:13pm: -The Administrator activated the fire alarm at 4:11pm. -Resident #6 was sitting on her bed with her laptop computer. -The door to her bedroom was open and the fire alarm could be heard in the resident's room. Interview with Resident #6's on 08/15/23 at 4:14pm revealed: -She knew what the alarm sound was. -She heard the alarm when it was activated. -She knew what to do when she heard the alarm. -She "guessed the sound of the alarm did not register." The facility failed to ensure fire drills were conducted appropriately to ensure 6 of 6 residents living in the facility knew to respond to a fire alarm and exit the facility without being verbally prompted to do so. This failure was	C 100		

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C 100	Continued From page 10 detrimental to the health, safety, and welfare of the resident and constitutes a B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/15/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 29, 2023.	C 100		
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 refer 1 of 3 sampled residents (#1) who was diabetic and needed her toenails trimmed, to a podiatrist. The findings are: Review of Resident #1's current FL-2 dated 07/14/23 revealed: -Diagnoses included Schizophrenia disorder bipolar type, dependent personality disorder, hypertension, obesity, and diabetes. -The resident was semi-ambulatory. -The resident required assistance with bathing and dressing. Review of Resident #1's care plan dated 10/25/22 revealed: -The resident was ambulatory with a walker. -The resident required limited assistance with ambulation, bathing, dressing, grooming, and	C 246		

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C 246	Continued From page 11 transfers. Review of the after-visit summary from Resident #1's podiatrist provider revealed: -Resident #1 was seen on 01/16/23. -Resident #1 was to follow up in 4 months. -Resident #1 had an appointment scheduled for 05/18/23 at 8:15am. Observation of Resident #1's toenails on 08/15/23 at 11:31am revealed: -The first toenail on her left foot was three-fourths of an inch past the end of her toe. -The second toenail on her left foot was one-eighth of an inch past the end of her toe; the underside of the toenail was black with a build-up of grime. -The third toenail on her left foot was one-half an inch past the end of the toe and was broken and jagged. -The third toenail on her left foot was one-half an inch past the end of the toe. -The fifth toenail on her left foot was broken in the nailbed. -The first toenail on her right foot was three-fourths of an inch past the end of her toe. -The third toenail on her right foot was one-half an inch past the end of the toe and was curling toward the toe; the underside of the toenail had a build-up of grime. -The fourth toenail on her right foot was one-eighth of an inch past the end of the toe; the underside of the toenail had a build-up of grime -The fifth toe had a build-up of grime around the cuticle of the toe. Interview with Resident #1 on 08/15/23 at 11:35am revealed: -Her toenails needed to be cut; she did not recall when her toenails had last been cut.	C 246		

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C 246	Continued From page 12 -She did not know if she had an appointment to get her toenails cut. -She was diabetic. -She would cut her toenails herself but she could not reach them. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She provided Resident #1 with a pan of warm water to "wash up" but the resident washed her own feet. -Resident #1's toenails grew "really fast." -The Assistant Administrators handled scheduling and coordinating podiatry appointments. -She did not know if Resident #1 had missed a podiatry appointment. -She knew Resident #1's toenails were getting on the "long side" but she had not told the Assistant Administrator. Telephone interview with Resident #1's primary care provider (PCP) on 08/15/23 at 2:42pm revealed: -If Resident #1's toenails were long, they needed to be clipped. -Diabetics would generally see a podiatrist for foot/nail care quarterly for regular maintenance. -Diabetics needed to be seen by a podiatrist to ensure their skin was not clipped during foot care. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed: -He was not aware Resident #1's toenails were long and needed to be cut. -He thought he had rescheduled Resident #1's podiatry appointment that was scheduled for 05/18/23, but when he called today, 08/15/23, they had it marked as a no-call, no-show. -He was able to make Resident #1 an appointment with the Podiatrist for 08/16/23.	C 246		

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C 246	Continued From page 13 Attempted telephone interview with Resident #1's podiatrist on 08/15/23 at 3:02PM was unsuccessful.	C 246		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure clarification of medication orders for 2 of 3 sampled residents (#1, #2) related to an order for a medication used to treat diabetes (#1) and an eye drop used to treat glaucoma (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 07/14/23 revealed: -Diagnosis included diabetes. -There was an order for Glipizide (a medication used to treat diabetes) extended-release (ER) 5mg one tablet daily.	C 315		

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NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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 315	Continued From page 14 Review of Resident #1's progress notes and physician's orders revealed no documentation the Glipizide order had been clarified. Review of Resident #1's June 2023 medication administration record (MAR) revealed: -There was an entry for Glipizide ER 10mg daily with a scheduled administration time of 8:00am. -There was documentation that Glipizide ER 10mg was administered at 8:00am from 06/01/23-06/30/23. Review of Resident #1's July 2023 MAR revealed: -There was an entry for Glipizide ER 10mg daily with a scheduled administration time of 8:00am. -There was documentation that Glipizide ER 10mg was administered at 8:00am from 07/01/23-07/31/23. Review of Resident #1's August 2023 MAR for 08/01/23-08/15/23 revealed: -There was an entry for Glipizide ER 10mg daily with a scheduled administration time of 8:00am. -There was documentation that Glipizide ER 10mg was administered at 8:00am from 08/01/23-08/15/23. Observation of Resident #1's medications on hand on 08/15/23 at 10:33am revealed Glipizide ER 10mg was dispensed on 08/07/23 and available to be administered. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 2:11pm revealed: -Resident #1's current order was dated 04/11/23 for Glipizide ER 10mg daily. -They dispensed Glipizide ER 10mg for Resident #1.	C 315		

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C 315	Continued From page 15 -They had never had an order for Glipizide ER 5mg for Resident #1. -They did not receive Resident #1's FL-2 dated 07/14/23. -They did not expect the facility staff to send FL-2s to the pharmacy unless there was a change in the residents' medications. -If they had received Resident #1's FL-2 dated 07/14/23, they would have called the facility to see if they were aware of the change in Resident #1's Glipizide dosage and called the resident's primary care provider (PCP) to make sure the dosage had been changed and was not a documentation error. Telephone interview with Resident #1's PCP on 08/15/23 at 2:42pm revealed: -She had not made any changes in the dosage of Glipizide for Resident #1 so if the current order was for 10mg, the FL-2 should have been completed for Glipizide 10mg, not 5mg. -The facility staff should have clarified what was the current order for Resident #1's Glipizide when the FL-2 did not match the medication being administered to the resident. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She administered Resident #1's Glipizide every day. -She did not know Resident #1's FL-2 had Glipizide as 5mg; the Administrators handled the FL-2's. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed he was not aware Resident #1's FL-2 had Resident #1's Glipizide dosage as 5mg and the MAR and medication sent from the pharmacy was Glipizide 10mg.	C 315		

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C 315	Continued From page 16 Refer to the interview with the MA on 08/15/23 at 4:20pm. Refer to the interview with the Assistant Administrator on 08/15/23 at 4:52pm. Refer to the interview with another Assistant Administrator on 08/15/23 at 4:52pm. Refer to the telephone interview with the facility's contracted PCP on 08/15/23 at 2:42pm. 2. Review of Resident #2's current FL-2 dated 07/14/23 revealed: -Diagnoses included catatonia schizophrenia, diabetes mellitus, hypertension, and mixed hyperlipidemia. -There was an order for Brimonidine (used to lower pressure in the eyes in patients who have glaucoma) 0.2% one drop in each eye twice daily. Review of Resident #2's progress notes and orders revealed no documentation that the Brimonidine order had been clarified. Review of Resident #2's Ophthalmologist after-visit summary dated 07/21/23 revealed: -Resident #1's medication list had Brimonidine 0.2% listed as one drop in both eyes three times daily. -There was no documentation that there had been any changes in the Brimonidine dosage. Review of Resident #2's June 2023 medication administration record (MAR) revealed: -There was an entry for Brimonidine 0.2% one drop in each eye three times daily; there were no times scheduled. -There was documentation that Brimonidine 0.2% was administered three times daily from	C 315		

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C 315	Continued From page 17 06/01/23-06/30/23. Review of Resident #2's July 2023 MAR revealed: -There was an entry for Brimonidine 0.2% one drop in each eye three times daily; there were no times scheduled. -There was documentation that Brimonidine 0.2% was administered three times daily from 07/01/23-07/27/31. -The dates of 07/28/23-07/31/23 were marked through with a single line; there was no documentation as to why the medication was not documented as administered. Review of Resident #2's August 2023 MAR for 08/01/23-08/15/23 revealed: -There was an entry for Brimonidine 0.2% one drop in each eye three times daily; there were no times scheduled. -There was documentation that Brimonidine 0.2% was administered three times daily from 08/01/23-08/07/23. -There were exceptions documented from 08/08/23-08/15/23 as medication ran out too fast; waiting for eye drops until 08/17/23. Observation of Resident #2's medications on hand on 08/15/23 at 1:15pm revealed Brimonidine 0.2% was dispensed on 07/11/23 with the directions to instill one drop in each eye three times daily. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 2:11pm revealed: -Resident #2's current order dated 03/23/23 was Brimonidine 0.2%, one drop in each eye three times daily. -They had never had an order for Brimonidine 0.2% twice daily.	C 315		

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C 315	Continued From page 18 -They did not receive Resident #2's FL-2 dated 07/14/23. -They did not expect the facility staff to send FL-2s to the pharmacy unless there was a change in the residents' medications. -If they had received Resident #1's FL-2 dated 07/14/23, they would have called the facility to see if they were aware of the change in Resident #2's Brimonidine 0.2% dosage and called the resident's primary care provider (PCP) to make sure the dosage had been changed and was not a documentation error. Interview with Resident #2 on 08/15/23 at 1:22pm revealed: -She had an order for Brimonidine eye drops to help with the pressure in her eyes. -She was supposed to get Brimonidine eye drops three times per day in each eye. -She recently saw her Ophthalmologist and the frequency had not been changed to twice a day. Telephone interview with Resident #1's PCP on 08/15/23 at 2:42pm revealed: -She knew Resident #2 had recently seen her Ophthalmologist, but she did not think there had been any changes in the resident's orders. -She was not aware the frequency for the Brimonidine eye drops had been listed on the FL-2 as twice daily if Resident #2's order had always been three times per day. -The facility staff should have clarified what was the current order for Resident #2's Brimonidine eye drops when the FL-2 did not match the medication being administered to the resident. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She administered Resident #2's Brimonidine eye drops three times daily.	C 315		

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C 315	Continued From page 19 -She did not know that Resident #2's FL-2 had Brimonidine eye drops documented as twice daily instead of three times daily; the Administrators handled the FL-2s. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed he was not aware Resident #1's FL-2 had Resident #2's Brimonidine eye drops documented as twice daily, and the MAR and medication sent from the pharmacy was three times daily. Refer to the interview with the MA on 08/15/23 at 4:20pm. Refer to the interview with the Assistant Administrator on 08/15/23 at 4:52pm. Refer to the interview with another Assistant Administrator on 08/15/23 at 4:52pm. Refer to the telephone interview with the facility's contracted PCP on 08/15/23 at 2:42pm. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She administered medication based on comparing the resident's medications delivered from the pharmacy to the resident's MAR. -She did not review the resident's FL-2s. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed: -He did not know who completed the FL-2s the PCP signed on 07/14/23 but he thought it was the PCP. -The PCP was updating all the resident's paperwork including the FL2s. -When the FL-2 was signed by the PCP he put it in the resident's record.	C 315		

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C 315	Continued From page 20 -He did not review the FL-2 but knew the PCP was not making any medication changes. -He did not fax the FL-2 to the pharmacy. -He audited the medications on hand to the MAR and the current FL2s, two weeks ago, and he missed the discrepancy on the FL-2. Interview with another Assistant Administrator on 08/15/23 at 4:52pm revealed FL-2s should be reviewed and if there were any discrepancies notify the PCP for clarification. Telephone interview with the facility's contracted PCP on 08/15/23 at 2:42pm revealed: -She had taken over the care of the residents at the facility recently, but she did not recall the date. -She had discussed with the facility her initial plan was to continue all of the residents' current medications and would adjust the medications if needed, as she assessed the resident and what their needs were. -Staff at the facility were to complete the FL-2s based on the residents' current medication list. -She signed the FL-2s based on what she thought was current and accurate for the residents' current medication orders.	C 315		
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	C 330		

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C 330	Continued From page 21 and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 3 sampled residents (#1, #2, and #3) related to cream used for itching (#1), an eye drop used to treat glaucoma (#2), and a medication used to treat hypertension and tremors (#3). 1. Review of Resident #2's current FL-2 dated 07/14/23 revealed: -Diagnoses included catatonia schizophrenia, diabetes mellitus, hypertension, and mixed hyperlipidemia. -There was an order for Brimonidine (used to lower pressure in the eyes in patients who have glaucoma) 0.2% one drop in each eye twice daily. Review of Resident #2's progress notes and orders revealed no documentation that the Brimonidine order had been clarified. Review of Resident #2's Ophthalmologist after-visit summary dated 07/21/23 revealed: -Resident #1's medication list had Brimonidine 0.2% listed as one drop in both eyes three times daily. -There was no documentation that there had been any changes in the Brimonidine dosage. Review of Resident #2's June 2023 medication administration record (MAR) revealed: -There was an entry for Brimonidine 0.2% one drop in each eye three times daily; there were no times scheduled. -There was documentation that Brimonidine 0.2% was administered three times daily from 06/01/23-06/30/23.	C 330		

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C 330	Continued From page 22 Review of Resident #2's July 2023 MAR revealed: -There was an entry for Brimonidine 0.2% one drop in each eye three times daily; there were no times scheduled. -There was documentation that Brimonidine 0.2% was administered three times daily from 07/01/23-07/27/31. -The dates of 07/28/23-07/31/23 were marked through with a single line; there was no documentation as to why the medication was not documented as administered. Review of Resident #2's August 2023 MAR for 08/01/23-08/15/23 revealed: -There was an entry for Brimonidine 0.2% one drop in each eye three times daily; there were no times scheduled. -There was documentation that Brimonidine 0.2% was administered three times daily from 08/01/23-08/07/23. -There were exceptions documented from 08/08/23-08/15/23 as medication ran out too fast; waiting for eye drops until 08/17/23. Observation of Resident #2's medications on hand on 08/15/23 at 1:15pm revealed a bottle of Brimonidine 0.2% was dispensed on 07/11/23 with the directions to instill one drop in each eye three times daily; the medication bottle was empty. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 2:11pm revealed: -Resident #2's current order dated 03/23/23 was Brimonidine 0.2%, one drop in each eye three times daily. -The Brimonidine had been dispensed on 04/17/23, 05/09/23, 06/29/23, and 07/11/23; each	C 330		

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C 330	Continued From page 23 dispensing was a 30-day supply according to the manufacturer. -The last refill of 07/11/23 was dispensed early because the facility reportedly had lost the bottle of eye drops dispensed on 06/29/23. -He received a request for Resident #2's eye drops to be refilled on 08/05/23, but there were no refills on the prescription. -A refill request had been sent to the original prescriber, a [named] eye doctor on 08/05/23. -Brimonidine eye drops were for the treatment of glaucoma and if the resident went without the medication for a length of time there could be an increase in ocular pressure; he did not know the length of time "right off" that could affect the ocular pressure. Interview with Resident #2 on 08/15/23 at 1:22pm revealed: -She had an order for Brimonidine eye drops to help with the pressure in her eyes. -She was supposed to get Brimonidine eye drops three times per day in each eye. -She had not received her Brimonidine eye drops today, 08/15/23. -She did not recall when she last received her Brimonidine eye drops but it had been more than two weeks. -The medication aide (MA) told her the medication had run out and it was too early to reorder and could not be reordered again until 08/17/23. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She administered Resident #2's Brimonidine eye drops three times daily. -She had not administered Resident #2's eye drops today because the medication had run out. -She did not recall when she last administered	C 330		

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C 330	Continued From page 24 Resident #2's Brimonidine eye drops but thought it was one-day last week. -When she called the pharmacy, she did not recall when but the pharmacy staff told her it was too early to order Resident #2's eye drops and that the insurance would not pay for them. -She had made a note to reorder Resident #2's eye drops on 08/17/23. -She was not there were no refills on Resident #2's Brimonidine eye drops, she was told it was too early to reorder the medication, but she did not recall who she talked to. Telephone interview with Resident #2's PCP on 08/15/23 at 2:42pm revealed: -She usually did not manage eye medications. -She had not received a request for a refill for Resident #2's Brimonidine eye drops from the pharmacy, but if she had she would have done a one-time refill until the resident's Ophthalmologist could be reached. -She had not been notified by facility staff, Resident #2's eye drops were out and needed to be refilled. -If the Brimonidine eye drops were not administered as ordered it could cause the resident's eye pressure to increase, but she was not concerned if the resident had not complained of dizziness or headaches. Second interview with Resident #2 on 08/15/23 at 3:00pm revealed she had not had any headaches or felt lightheaded. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed: -He was aware Resident #2's Brimonidine eye drops had been running out too soon, before time to refill, and the insurance would not pay for the refill.	C 330		

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C 330	Continued From page 25 -Before today, 08/15/23, he was not aware Resident #2 did not have Brimonidine eye drops available to be administered. -He was told Resident #2's Brimonidine eye drops were getting "low", and the insurance would not pay to get it refilled; he thought he was told on 08/04/23 or 08/07/23. -He did not reach out to Resident #2's PCP or Ophthalmologist because he thought if the insurance would not pay for it, there was nothing that could be done until it was time to refill the medication again. 2. Review of Resident #3's current FL-2 dated 07/14/23 revealed diagnoses included hypertension, moderate intellectual disability, severe bipolar affective disorder, and aggression. Review of Resident #3's primary care provider (PCP) order dated 06/10/23 revealed an order to start Propranolol [used to treat high blood pressure (BP) and tremors] 40mg twice daily for hypertension and essential tremors. Review of Resident #3's June 2023 medication administration record (MAR) revealed there was no entry for Propranolol and no documentation that Propranolol 40mg was administered. Review of Resident #3's July 2023 MAR revealed there was no entry for Propranolol and no documentation that Propranolol 40mg was administered. Review of Resident #3's August 2023 MAR for 08/01/23-08/15/23 revealed there was no entry for Propranolol and no documentation that Propranolol 40mg was administered. Review of Resident #3's BP readings revealed:	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/15/2023
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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 330	Continued From page 26 -On 05/01/23, Resident #3's BP was documented as 153/94. -On 06/01/23, Resident #3's BP was documented as 98/65. -On 07/01/23, Resident #3's BP was documented as 144/97. -On 08/01/23, Resident #3's BP was documented as 103/75. Observation of Resident #3's medications on hand on 08/15/23 at 12:38pm revealed a medication pack dispensed on 08/11/23 for 14 tablets of Propranolol 40mg take one tablet twice daily; 7 tablets had been punched from the medication pack. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 2:11pm revealed: -An order was received on 08/11/23 for Resident #3's Propranolol 40mg once daily; it was listed on the order the medication was for hypertension and tremors. -A 7-day supply (14 tablets) of Propranolol 40mg was dispensed on 08/11/23, to cover the medication until the cycle fill was dispensed. -The order was dated 06/06/23. -If the resident did not receive the Propranolol as ordered the resident could experience an increase in their BP and their tremors would not improve. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She saw the order for Resident #3's Propranolol last Friday, 08/11/23, and she faxed it to the pharmacy. -She had not seen the medication at the facility, so she thought the order needed to be faxed to the pharmacy.	C 330		

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C 330	Continued From page 27 -She had not administered Resident #3's Propranolol because the medication had not been delivered to the facility. -She had not seen the individual medication packet dispensed on 08/11/23 for fourteen tablets. -She did not know who had administered the seven missing tablets of Propranolol for Resident #3. -She left the facility on 08/11/23 and returned on 08/14/23. Second interview with the MA on 08/15/23 at 4:42pm revealed she had administered Resident #3's Propranolol, but she had "forgotten she did." Telephone interview with Resident #3's PCP on 08/15/23 at 2:42pm revealed: -She had seen Resident #3 since she wrote the order on 06/06/23. -She did not have the resident's BP readings in front of her, but she thought Resident #3's BP had been "fine" the last time she saw the resident. -She assumed Resident #3 had been administered the Propranolol. -She ordered Propranolol for Resident #3's because the resident's BP had been slightly elevated, and the resident had complained of tremors. -If Resident #3's Propranolol was not administered as ordered the resident's BP would not be controlled and her tremors would have continued. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed: -He had not seen the order for Resident #3's Propranolol. -He was concerned the order was not sent to the	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/15/2023
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C 330	Continued From page 28 pharmacy when it was written, on 06/06/23. -The concern was Resident #3's PCP wrote the order for a reason and the order was not sent to the pharmacy so the medication could be dispensed and administered. -New orders were supposed to be faxed to the pharmacy by whoever received the order and then placed on the inside of the MAR logbook. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable. 3. Review of Resident #1's current FL-2 dated 07/14/23 revealed: -Diagnoses included Schizophrenia disorder bipolar type, dependent personality disorder, hypertension, obesity, and diabetes. -There was an order to apply Triamcinolone acetonide (used to treat swelling and itching of the skin) 0.1% to the affected area twice daily. Review of Resident #1's June 2023 medication administration record (MAR) revealed: -There was an entry for Triamcinolone acetonide 0.1% apply to the affected area twice daily at 8:00am and 8:00pm. -There was documentation that Triamcinolone acetonide 0.1% was administered twice daily from 06/01/23-06/30/23. Review of Resident #1's July 2023 MAR revealed: -There was an entry for Triamcinolone acetonide 0.1% apply to the affected area twice daily at 8:00am and 8:00pm. -There was documentation that Triamcinolone acetonide 0.1% was administered twice daily from 07/01/23-07/27/31. Review of Resident #1's August 2023 MAR for	C 330		

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C 330	Continued From page 29 08/01/23-08/15/23 revealed: --There was an entry for Triamcinolone acetonide 0.1% apply to the affected area twice daily at 8:00am and 8:00pm. -There was documentation that Triamcinolone acetonide 0.1% was administered twice daily from 08/01/23-08/07/23. Observation of Resident #1's medications on hand on 08/15/23 at 11:01am revealed a tube of Triamcinolone acetonide 0.1% was dispensed on 08/08/23; the tube had not been opened. Interview with the medication aide (MA) on 08/15/23 at 11:25am revealed: -She applied a cream to Resident #1's bottom today, 08/15/23. -She applied the cream that was in a white bottle. -She did not know where she had put the white bottle. -She ordered Resident #1's Triamcinolone acetonide 0.1% cream because the white bottle was getting low. Interview with Resident #1 on 08/15/23 at 11:35am revealed: -It had been "a while", "months" since anyone had applied cream to her "bottom." -She had scratched her bottom, it was a nervous habit, and her primary care provider (PCP) had ordered a cream to be applied. -She did not think she needed the cream because the area had healed. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 2:11pm revealed: -Resident #1's current order dated 03/04/23 or 03/11/23 was for Triamcinolone acetonide 0.1% apply to the affected area twice daily, and was	C 330		

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C 330	Continued From page 30 dispensed on 08/09/23; there had been no other dispensing. -They took over the facility's pharmacy services on 02/28/23. Telephone interview with Resident #2's PCP on 08/15/23 at 2:42pm revealed: -She expected medications to be administered as ordered. -If Resident #1's skin condition had improved, the facility staff could ask for the medication to be discontinued. -She did not know if Resident #1's Triamcinolone acetonide 0.1% needed to be administered because she did not know if the skin had improved or not. Interview with an Assistant Administrator on 08/15/23 at 4:52pm revealed: -The MA told her Resident #1 still had a problem with her skin and needed the Triamcinolone cream. -The Triamcinolone cream should be applied twice daily as directed. Second interview with the MA on 08/15/23 at 4:30pm revealed: -She located Resident #1's bottle of Triamcinolone acetonide 0.1% cream. -Resident #1 did not have any scratches "right now" but she applied the Triamcinolone acetonide 0.1% to Resident #1 to be on the safe side. -She applied Triamcinolone acetonide 0.1% once every day, not every day but a few days a week. -She did not apply Triamcinolone acetonide 0.1%, yesterday, 08/14/23, but she knew she had applied the Triamcinolone acetonide 0.1% a few days last week (the week of 08/07/23) because she had seen blood stains on Resident #1'S bed sheets.	C 330		

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C 330	Continued From page 31 Observation of the bottle of Resident #1's Triamcinolone acetonide 0.1% provide by the MA on 08/15/23 at 4:30pm revealed: -The bottle was dispensed on 04/22/22 with the directions to apply topically to the affected area twice daily. -There was approximately one-fourth of the medication in the container. -The bottle was dispensed from the facility's previously contracted pharmacy. Observation of Resident #1's upper back/side of her left thigh on 08/15/23 at 7:01pm revealed a red rash approximately 6 inches by 3 inches with multiple raw areas. Second interview with Resident #1 on 08/15/23 at 7:01pm revealed: -She did not recall when she had scratched her leg, but she did it when she was nervous. -She probably needed to cut her fingernails so she would stop scratching.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and	C 342		

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C 342	Continued From page 32 documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records were accurate for 2 of 3 sampled residents (#1, #3) including documenting a medication used to soften calluses that had not been dispensed (#1) and a medication used to treat high blood pressure and tremors that had not been documented (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/14/23 revealed: -Diagnoses included Schizophrenia disorder bipolar type, dependent personality disorder, hypertension, obesity, and diabetes. -There was an order to apply Urea (used to soften calluses) 40% cream apply to the callus on the left great day twice daily. Review of Resident #1's June 2023 medication administration record (MAR) revealed: -There was an entry for Urea 40% apply to the left great day twice daily at 8:00am and 8:00pm. -There was documentation that Urea 40% was applied twice daily from 06/01/23-06/30/23. Review of Resident #1's July 2023 MAR revealed:	C 342		

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C 342	Continued From page 33 -There was an entry for Urea 40% apply to the left great day twice daily at 8:00am and 8:00pm. -There was documentation that Urea 40% was applied twice daily from 07/01/23-07/27/31. Review of Resident #1's August 2023 MAR for 08/01/23-08/15/23 revealed: -There was an entry for Urea 40% apply to the left great day twice daily at 8:00am and 8:00pm. -There was documentation that Urea 40% was applied twice daily from 08/01/23-08/07/23. -The dates of 08/01/23-08/07/23 were marked out with a large X and D/C was handwritten in. Observation of Resident #1's medications on hand on 08/15/23 at 11:01am revealed there was no Urea 40% available to be applied. Interview with the medication aide (MA) on 08/15/23 at 11:25am revealed: -She applied a cream to Resident #1's toe, but the toe had healed, and she stopped applying the medication. -She did not recall the last time she applied the medication. -She did not know if there was an order to discontinue Resident #1's cream, but the toe had healed. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 2:11pm revealed: -They received signed physician's orders from the previous pharmacy dated 03/06/23 and Urea 40% was listed as an active order. -Resident #1's Urea 40% had not been dispensed by their pharmacy. Telephone interview with the Pharmacist at the facility's previously contracted pharmacy on	C 342		

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C 342	Continued From page 34 08/15/23 at 3:08pm revealed: -An order for Resident #1's Urea 40% had been received but the medication was not filled. -The medication may have not been filled because the cream was not covered by insurance and was expensive. Interview with an Assistant Administrator on 08/15/23 at 4:52pm revealed: -She recalled Resident #1's Urea cream was expensive, the Podiatrist had been notified and the order was discontinued. -She would locate the discontinued order. Second interview with the MA on 08/15/23 at 4:30pm revealed: -She thought she had applied the same medication to Resident #1's toe that she had applied to Resident #1's scratches on her thigh, Triamcinolone acetonide 0.1% cream. -She did not know if Resident #1 ever had Urea 40% cream. -The cream she applied worked as the resident's callus was healed. -She documented Urea cream was to the callus on the left toe because she applied a cream to the resident's toe. Review of a facsimile received on 08/09/23 at 1:04pm revealed there was documentation from Resident #1's Podiatry office the Urea 40% cream had been discontinued on 01/11/23. 2. Review of Resident #3's current FL-2 dated 07/14/23 revealed diagnoses included hypertension, moderate intellectual disability, severe bipolar affective disorder, and aggression. Review of Resident #3's primary care provider (PCP) order dated 06/10/23 revealed an order to	C 342		

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C 342	Continued From page 35 start Propranolol [used to treat high blood pressure (BP) and tremors] 40mg twice daily for hypertension and essential tremors. Review of Resident #3's June 2023 medication administration record (MAR) revealed there was no entry for Propranolol and no documentation that Propranolol 40mg was administered. Review of Resident #3's July 2023 MAR revealed there was no entry for Propranolol and no documentation that Propranolol 40mg was administered. Review of Resident #3's August 2023 MAR for 08/01/23-08/15/23 revealed there was no entry for Propranolol and no documentation that Propranolol 40mg was administered. Observation of Resident #3's medications on hand on 08/15/23 at 12:38pm revealed a medication pack dispensed on 08/11/23 for 14 tablets of Propranolol 40mg take one tablet twice daily; 7 tablets had been punched from the medication pack. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 2:11pm revealed: -An order was received on 08/11/23 for Resident #3's Propranolol 40mg once daily; it was listed on the order the medication was for hypertension and tremors. -A 7-day supply (14 tablets) of Propranolol 40mg was dispensed on 08/11/23, to cover the medication until the cycle fill was dispensed. -He did not know if a MAR was sent with the medication, but the MA could handwrite the directions on the MAR until the next month's MAR was delivered.	C 342		

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C 342	Continued From page 36 Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She had not administered Resident #3's Propranolol because the medication had not been delivered to the facility. -She had not seen the individual medication packet dispensed on 08/11/23 for fourteen tablets. -She did not know who had administered the seven missing tablets of Propranolol for Resident #3. -She did not document on the MAR because she had not administered the medication. Second interview with the MA on 08/15/23 at 4:42pm revealed she had administered Resident #3's Propranolol, but she had "forgotten she did" and she forgot to document it on the MAR. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed: -Staff were expected to document on the MAR when medications were administered. -He had not checked the August 2023 MARs or done a cart audit since Resident #3's Propranolol had been dispensed.	C 342		
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.	C 367		

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C 367	Continued From page 37 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substances was maintained for 1 of 1 sampled resident (Resident #3) who had an order for a controlled substance pain medication. The findings are: Review of Resident #3's current FL-2 dated 07/14/23 revealed diagnoses included hypertension, moderate intellectual disability, severe bipolar affective disorder, and aggression. Review of Resident #3's controlled substance count sheet (CSCS) dated 05/09/22 revealed: -Acetaminophen/Codeine #3 take one tablet by mouth every four hours as needed for pain was dispensed on 05/09/22 for twenty; there were no refills. -There was documentation that Resident #3 was administered an Acetaminophen/Codeine #3 on 05/09/22, 05/13/22, and 05/14/22 at 8:00pm, with a remaining balance of 17. Review of Resident #3's medication administration record (MAR) for May 2022 revealed: -There was an entry for Acetaminophen/Codeine #3 take one tablet by mouth every four hours as needed for pain. -Acetaminophen/Codeine #3 was documented as administered 05/09/22, 05/13/22, 05/14/22, and 05/15/22 at 8:00pm and the medication was effective; four doses were documented as administered. Review of Resident #3's MAR for June 2022	C 367		

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C 367	Continued From page 38 revealed: -There was an entry for Acetaminophen/Codeine #3 take one tablet by mouth every four hours as needed for pain. -Acetaminophen/Codeine #3 was documented as administered 06/01/22 at 6:00pm, 06/03/22 at 8:00pm, 06/04/22 at 10:00pm, 06/06/22 at 8:00pm, 06/22/22 at 8:00pm, 06/23/22 at 10:00pm, 06/24/22 at 7:00pm, 06/25/22, 06/26/22, and 06/27/22 at 8:00pm and the medication was effective; nine doses were documented as administered. Review of Resident #3's CSCS revealed there was no CSCS for June 2022. Review of Resident #3's MAR for July 2022 revealed: -There was an entry for Acetaminophen/Codeine #3 take one tablet by mouth every four hours as needed for pain. -Acetaminophen/Codeine #3 was documented as administered 07/09/22, 07/13/22, 07/22/22, 07/28/22, 07/29/22, and 07/30/22 at 8:00pm and the medication was effective; six doses were documented as administered. Review of Resident #3's CSCS revealed there was no CSCS for July 2022. Interview with the medication aide (MA) on 08/15/23 at 4:20pm revealed: -She always documented on the MAR and the CSCS when she administered controlled medication. -She did not know where Resident #3's CSCS was for June 2022 and July 2022. -It had been over a year, and she did not know where the CSCS could be but she knew she documented on the CSCS.	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017052	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/15/2023
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
(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 367	Continued From page 39 Telephone interview with the Pharmacist at the facility's previously contracted pharmacy on 08/15/23 at 3:08pm revealed: -A four-day supply of Acetaminophen/Codeine #3 take one tablet by mouth every four hours as needed for pain was dispensed on 05/09/22 for twenty tablets for Resident #3; there were no refills. -CSCS should be used with all controlled medication to keep tighter control of the medication due to abuse and/or diversion. Interview with the Assistant Administrator on 08/15/23 at 4:52pm revealed: -CSCS was to be used for documentation when controlled medications were administered. -He did not know where the CSCS for June 2022 and July 2022 were located. -He and another Assistant Administrator had looked for the CSCS and were not able to locate it. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable.	C 367		