

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL 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)	COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an Annual and Follow-Up survey on February 29, 2024.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors accessible to a resident, who was identified as intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the resident (#1). The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of Resident #1's current FL-2 dated 09/13/23 revealed:	C 069	Effective March 11, 2024, Administrator installed Sanjie Door Chime, Door Open /Contact Sensor Alarm for Facility exterior doors to meet the following rule 10A NCAC 13G .0312(g) Outside Entrance and Exits 10A NCAC 13G .0312 Outside Entrance and Exits SIC will be monitoring this daily when she opens the doors for the day, and IF the chime is not working, SIC will immediately notify maintenance.	03/11/2024

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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

JP6C11

If continuation sheet 1 of 22

Reviewed and acknowledged 03/25/24.

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

JEFFERSON CARE HOME #4

**495 STALEY BOSWELL ROAD
YANCEYVILLE, NC 27379**

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C 069	Continued From page 1 -Diagnoses included other intellectual disabilities. -Resident #1 was intermittently disoriented. Observations of the facility's exit doors at various times on 02/29/24 between 8:00am-6:00pm revealed the residents were seen entering and exiting the facility through the front exit door at various times before and after their day program and no alarms sounded. Interview with the Supervisor in Charge (SIC) on 02/29/24 at 11:33am revealed: -Resident #1 did not have any problems with his memory. -The residents' primary care provider (PCP) completed the FL-2s. -She did not know why Resident #1's FL-2 had the resident listed as intermittently disoriented. Interview with the SIC on 02/29/24 at 5:52pm revealed: -The facility had two exit doors, the front door, and the door by her bedroom door. -The exit doors did not have alarms. -She would not know if a resident went outside. -Resident #1 never went outside unless he was going to the day program. -She locked the kitchen door, which was adjacent to her bedroom door at night, but she could hear when the residents shut the door to the bathroom. Telephone interview with Resident #1's primary care provider (PCP) on 02/29/24 at 5:47pm revealed Resident #1 might wander away from the facility; there was a possibility. Interview with the Co-Administrator on 03/06/24 at 11:53am and 6:00pm revealed: -He did not think Resident #1 was intermittently disoriented.	C 069		

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C 069	Continued From page 2 -Resident #1's PCP completed the FL-2. -He had not noticed Resident #1's FL-2 had the resident listed as intermittently disoriented. -He did not know the facility needed to have a sounding device that was activated when the door was opened.	C 069		
C 259	Based on reviews, interviews, and observations, Resident #1 was not interviewable. 10A NCAC 13G .0904(a)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (3) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule, for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to have a 5-day supply of non-perishable foods based on the census and the menus in the facility as evidence of the food pantry having	C 259	Effective March 04, 2024, Administrator purchased a tote and purchased 5-8-day worth of non- perishable items and dated. The tote will be filled with Non-perishable. Items. Including, Canned Foods: tuna. Soups, stews, chili, gravy, and sauces. Pasta. Fruits and vegetables. Bean. ... Dried Goods. Soups. Mixtures, Coffee Tea bags. Powdered milk. Grains. ... Granulated sugar. Peanut butter, honey. Bottled Water Stored in inside of the kitchen closet and Staff will place an expiration date on the outside of the tote. 2 weeks before the expiration date I will substitute my Non-perishable food items for the menu and replace the Non-Perishable items SIC and Administrator to monitor monthly to ensure that this policy is being met. Ensuring that rule 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: is being met.	03/04/2024

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C 259	Continued From page 3 limited food items stored. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents; there were 5 residents residing in the facility. Observations of the food pantry/cabinets in the facility on 02/29/24 at 8:24am revealed: -There were six boxes of pancake mix; each box contained 16 servings. -There was one bag of grits; the bag contained approximately 49 one-fourth-cup servings. -There was a container of oatmeal; the container contained approximately 30 one-half-cup servings. -There were two cans of garbanzo beans; each can contained approximately 3.5 one-half cup servings. -There were five cans of diced potatoes; each can contained approximately 2.5 one-third cup servings. -There were three cans of baked beans; each can contained approximately 24 one-half-cup servings. -There were two cans of cut green beans; each can contained approximately 24 one-half-cup servings. -There was a jar of peanut butter with less than one-fourth of a cup of peanut butter remaining in the container. -There was one can of canned meat; the can contained 6 two-ounce servings. -There were five individual cans of canned meat, each can contained one serving. -There were 15 four-ounce containers of sliced peaches. -There were 36 four-ounce cups of diced pears.	C 259		

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C 259	Continued From page 4 Review of the facility's breakfast menu for one meal service revealed: -Four ounces of orange juice were to be served. -Three-fourths of a cup of cereal was to be served. -One scrambled egg was to be served. -One-half cup of a mixed fruit cup was to be served. Review of the facility's lunch menu for one meal service revealed: -Two to three ounces of meat were to be served. -One-half cup of vegetables was to be served. -One serving of bread was to be served. -One-half cup of a fruit cup was to be served. Review of the facility's dinner menu for one meal service revealed: -Three ounces of meat were to be served. -One cup of rice was to be served. -One-half cup of vegetables was to be served. -One serving of bread was to be served. -One-half cup of a fruit cup was to be served. Interview with the Supervisor in Charge (SIC) on 02/29/24 at 11:33am revealed: -The residents ate three meals per day at the facility on the weekends and only two meals during the week, breakfast, and dinner. -She mostly cooked using foods from the freezers. -There was a lot of meat and vegetables in the freezers. -She used what she had available to prepare meals for the residents. Interview with the Co-Administrator on 02/29/24 at 11:53am revealed: -He was not aware there needed to be a 5-day	C 259		

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C 259	Continued From page 5	C 259		
C272	supply of non-perishable food available at the facility. -Foods were delivered to a central location for all the facilities, and then each facility was supplied food based on what was needed. -Non-perishable food was always available in storage. 10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to offer snacks to the residents three times a day. Review of the facility's menu on 02/29/24 at 11:13am revealed: -A row labeled as a snack was listed at the bottom of the menu. -The snack did not have a time of the day documented. -The snack to be offered consisted of juice and cookies one day and juice and yogurt on another day.	C272	Effective March 11, 2024, SIC will monitor staff daily to ensure that the menu is being followed and that milk is offered at least twice a day. Two servings of fruit (one serving equals 6 ounces of juice, ½ cup raw, canned, or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried, or canned fruit. M-F anyone who does not go to the day program will be offered snacks during the day and every resident in the evenings and all residents will be provided a snack three times a day on the weekends. SIC to monitor meal servings for 6 weeks then continue with meal reviews bi-monthly with SIC and staff.	03/11/2024

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C 069	Continued From page 6 - Interview with a resident on 02/29/24 at 8:07am revealed he did not get snacks, just three meals per day; he would like to have snacks to eat between meals. Interview with three other residents on 02/29/24 between 8:08am-8:14am revealed they did not get snacks to eat, they wished they did. Interview with the Supervisor in Charge (SIC) on 02/29/24 at 11:33am revealed: -When she had snacks at the facility to give the residents, she gave the residents a snack at bedtime. -She had fruit cups, apple sauce, peaches, and peanut butter to give to the residents at times. -On the weekends, if she had it, she would give the residents a snack three times a day. -She did not give a snack three times per day over the weekend on 02/24/24-02/25/24 because she did not have one to give. -A named staff member brought fruit cups to the facility on 02/27/24. Interview with the Co-Administrator on 02/29/24 at 11:53am revealed: -The residents should be given snacks every day. -If there was no snack food available, the SIC should have called to let him know and he would have had food delivered.	C 069		
C292	10A NCAC 13G .0905 (d) Activities Program 10A NCAC 13G .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of	C292		

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C 292	Continued From page 7 new skills. This Rule is not met as evidenced by: Based on interviews and observations, the facility failed to ensure a minimum of 14 hours of planned group activities were planned each week, that promoted socialization, physical interactions, group accomplishment, creative expression, increased knowledge, and learning of new skills for the 6 residents living in the facility. The findings are: Observation on 02/29/24 at 11:35am revealed no activity calendar was posted at the facility. Observation of activities available at the facility on 02/29/24 at 11:35am revealed a container of dominoes and a bingo game. Observation of the facility on 02/29/24 between the hours of 8:00am and 6:00pm revealed: -All of the residents left the facility by 9:00am to go to a day program. -The residents returned to the facility by 4:00pm. -There we no activities observed between 4:00pm-6:00pm. Interview with a resident on 02/29/24 at 8:07am revealed: -There were no activities at the facility in the evenings or weekends. -He would like to have activities to do. Interview with two other residents on 02/29/24 between 8:11am-8:14am revealed: -There was no activity calendar in the facility. -There was nothing to do at the facility.	C 292	Effective 03/11/2024 Administrator ensured that Activities for the month of March 2024 calendar was updated and posted of for all current residents. Resident had a behavior and tore previous calendar down. Administrator was not aware that the calendar was broken by resident. Administrator re-installed white board. All of the residents are currently enrolled in a Day Program the one (1) resident(s) that do not attend the Day Program refuse board games (Bingo, Monopoly, Cards, Bible Study, Waking, Craft, or Chit Chat). Their activity of choice is sitting on the porch smoking cigarettes and watching their favorite programs on TV. Administrator as part of the on-boarding process has included on the orientation process to include the location of board games and to ensure that the Activity Calendar is updated monthly. Since most of the residents go to the day program- we will focus on offering activities in the evenings and the weekends that are of interest to the residents. Activity Director will monitor and log weekly that the rule 10ANCAC 13C 0905 (d) is being met. Administrator to verify with Activity Director monthly that this policy is being met.	03/11/2024

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C 292	Continued From page 8 -They would like to have activities to do at the facility. Interview with the Supervisor in Charge (SIC) on 02/29/24 at 11:33am revealed: -All of the residents went to a day program Monday-Friday. -The facility had a bingo game and cards available for the residents to play. -There was no activity calendar currently at the facility, but she thought the Co-Administrator had one to be posted. Interview with the Co-Administrator on 02/29/24 at 11:53am revealed: -He was responsible for doing the monthly activity calendar at the facility and typically had the calendar posted. -He thought he had taken a calendar to the facility to be posted. -The residents had participated in baking, playing cards, and attending a movie night at a community center at least monthly. -Over time, cards got lost, but he would purchase more.	C 292			
C315	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	C315			

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STATE FORM

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C 315	Continued From page 9 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 clarify orders for 3 of 3 residents sampled (#1, #2, and #3) including a medication used to treat anxiety, a mechanical soft diet, and order for weekly blood pressure (BP) (#1), a medication used to treat chronic obstructive pulmonary disease (COPD) and twice weekly finger stick blood sugar (FSBS) (#2), and order for twice daily BPs (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 09/13/23 revealed diagnoses of intellectual disabilities and abnormal weight loss. a. Review of Resident #1's current FL-2 dated 09/13/23 revealed an order for Lorazepam (used to treat anxiety) 0.5mg at bedtime. Review of Resident #1's previous FL-2 dated 09/15/22 revealed an order for Lorazepam 0.5mg twice daily. Review of Resident #1's medication administration record (MAR) for December 2023 revealed: -There was an entry for Lorazepam 0.5mg take one tablet twice daily with a scheduled administration time of 8:00am and 8:00p, -Lorazepam 0.5mg was documented as administered twice daily from 12/01/23-12/31/23. Review of Resident #1's MAR for January 2024	C 315	Effective date March 4, 2024, Administrator will ensure that all Medications Orders for residents from the prescribing practitioner shall be accurate per the current FL-2. Staff shall fax all hospital discharge notes requiring medication order changes to the facilities pharmacy and to the SIC who will fax a copy of medication change to the Administrator. Administrator will maintain a digital copy of all hospital discharges in resident book. Prescribing practitioner shall send all medication orders electronically directly to the facilities pharmacy and document on the residents Health Service sheet during monthly examination which will be maintained in the resident's book which will be kept at the facility. Prescribing practitioner held class on Documentation in November 2023 for current staff and Administrator will ensure that all future staff will take course on Documentation as part of the on-boarding employment process. SIC to monitor this policy weekly and report to the Administrator immediately if this policy is not being met. Administrator has instructed (Staff) to verify all medicine administered for resident(s) after every medication pass. SIC will review medication for resident(s) for 6 weeks. with staff. Immediately the staff will verify medication at the change of each shift, each employee will sign that the MAR is accurate. If the MAR/Medicine is not correct the (Staff) will immediately contact the SIC. SIC will contact all mediation aides to re-educate on the correct procedure on how to document on the MAR. Effective date May 2024 Administrator will schedule continued education on Medication Errors for current and future staff. Medication chart audits will be completed for all residents with all medications weekly by the SIC for 6 weeks and will continue with Medication reviews bi-monthly with SIC and staff.	03/04/2024

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STATE FORM

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C 315	Continued From page 10 revealed: -There was an entry for Lorazepam 0.5mg take one tablet twice daily with a scheduled administration time of 8:00am and 8:00p, -Lorazepam 0.5mg was documented as administered twice daily from 01/01/24-01/31/24. Review of Resident #1's MAR for February 2024 revealed: -There was an entry for Lorazepam 0.5mg take one tablet twice daily with a scheduled administration time of 8:00am and 8:00p, -Lorazepam 0.5mg was documented as administered twice daily from 02/01/24-02/28/24 and the 8:00am dose on 02/29/24. Review of Resident #1's physician's orders revealed no documentation the PCP was contacted to clarify the discrepancy in the order compared to the MARs. Observation of Resident #1's medications on hand on 02/29/24 at 11:23am revealed Lorazepam 0.5mg was dispensed on 02/28/24 with the directions to administer one tablet twice daily. Telephone interview with a pharmacy technician on 02/29/24 at 1:13pm revealed: -Resident #1's current order was for Lorazepam 0.5mg twice daily. -Resident #1's order for Lorazepam 0.5mg had been twice a day for a long time. -The pharmacy had not received Resident #1's FL-2 dated 09/13/23. -The pharmacy received an electronic script from Resident #1's primary care provider (PCP) on 09/19/23. -She would have expected the facility staff to have called to clarify the order when the FL-2 was	C315	placed in the Medication Room and in the front of the MAR book. RULE: Use the residents name and PICTURE! Prior to administering medication: • Right Medication • Right Dose • Right Time • Right Route • Right Patient Verify what they say against the information on the MAR. Does the information MATCH? If yes, then proceed to administer medication. If NO, the STOP!	

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C 315	Continued From page 11 received. Interview with the Supervisor in Charge (SIC) on 02/29/24 at 4:45pm revealed: -She administered Resident #1's Lorazepam based on the pharmacy label and compared it to the MAR. -She did not see the order on Resident #1's FL-2 dated 09/13/23 for Lorazepam 0.5mg to be administered once daily, at bedtime. Telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm revealed: -Resident #1's current order for Lorazepam was twice daily. -She took over for Resident #1's care in May 2023. -If she signed Resident #1's FL-2 on 09/13/23 for Lorazepam once daily, it was in error. -She would have expected the facility staff to have clarified the order. Interview with the Co-Administrator on 02/29/24 at 5:28pm revealed he did not see the order for Resident #1's Lorazepam on the FL-2 dated 09/13/23. Based on observations and interviews it was determined Resident #1 was not interviewable. Refer to the telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm. Refer to the interview with the SIC on 02/29/24 at 4:45pm. Refer to the interview with the Co-Administrator	C315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4			STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL 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)	COMPLETE DATE	
C315	Continued From page 12 b. Review of Resident #1's current FL-2 dated 09/13/23 revealed an order for blood pressures twice weekly. Review of Resident #1's medication administration record (MAR) for December 2023, January 2024, and February 2024 revealed: -There was no entry for BP checks for Resident #1. -There was no documentation on the front or back of the MARs for BP readings for Resident #1. Review of Resident #1's physician's orders revealed no documentation the PCP was contacted to clarify the order. Telephone interview with a pharmacy technician on 02/29/24 at 1:13pm revealed: -She did not have an order to check Resident #1's BPs weekly. -If the facility had an order to check Resident #1's BP, the order should be sent to the pharmacy. -The pharmacy would have put BP checks on Resident #1's MAR if the order was received. Interview with the SIC on 02/29/24 at 8:05am revealed there were no residents who had ordered BP checks. Second interview with the SIC on 02/29/24 at 4:45pm revealed: -She did not check Resident #1's BP weekly. -She did not see the order for Resident #1's BP checks on the FL-2 dated 09/13/23. Telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm revealed: -Resident #1 did not need to have weekly BP checks.	C 315			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL 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)	COMPLETE DATE
C 315	Continued From page 13 -She saw Resident #1 twice a month and checked his BP on each visit. Interview with the Co-Administrator on 02/29/24 at 5:28pm revealed he did not see the order for Resident #1's twice weekly BP checks on the FL-2 dated 09/13/23. Based on observations and interviews it was determined Resident #1 was not interviewable. Refer to the telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm. Refer to the interview with the SIC on 02/29/24 at 4:45pm. Refer to the interview with the Co-Administrator on 02/29/24 at 5:08pm. c. Review of Resident #1's current FL-2 dated 09/13/23 revealed an order for a mechanical soft diet. Review of the facility's diet list on 02/29/24 revealed Resident #1 was listed as a regular diet. Review of Resident #1's physician's orders revealed no documentation the PCP was contacted to clarify the discrepancy in the order. Interview with the SIC on 02/29/24 at 8:05am revealed there were no residents on therapeutic diets; all residents were on regular diets. Observation of the dinner meal service on 02/29/24 between 4:18pm-5:15pm revealed: -Resident #1 was served two Salisbury steak patties, two slices of white bread, broccoli and	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
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NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379
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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)	COMPLETE DATE
C 315	Continued From page 14 cheese, and white beans. -Resident #1 only took a bite of his bread for the first 15 minutes of the meal. -Resident #1 ate 100% of his meal without any noted difficulty. Interview with the SIC on 02/29/24 at 4:35pm and 4:45pm revealed: -Resident #1 did not like to eat in front of the other residents. -Once the other residents left the dining room, Resident #1 would eat all his meals. -Resident #1 had never had any problems with eating his food, and no problems with chewing. -She did not see the order for a mechanical soft diet on Resident #1's FL-2 dated 09/13/23. -No one had told her Resident #1 needed to be on a mechanical soft diet. Interview with the Co-Administrator on 02/29/24 at 5:28pm revealed: -He did not see the order for Resident #1's mechanical soft diet on the FL-2 dated 09/13/23. -If there was ever an order for Resident #1 to have a mechanical soft diet, it would have been temporary for something that was going on at that time. -He had never seen Resident #1 have any problems with eating a regular diet. Telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm revealed: -Resident #1 was able to have a regular diet. -Resident #1 had all his teeth and did not have any swallowing problems. -Resident #1 would sometimes need to be reminded to slow down and chew his food depending on his mood, but she did not think the resident needed a mechanical soft diet. -If she signed the FL-2 with an order for a	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

JEFFERSON CARE HOME #4

**495 STALEY BOSWELL 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)	COMPLETE DATE
C 315	Continued From page 15 mechanical soft diet it was in error. -She would have expected the facility staff to have clarified the order. Based on observations and interviews it was determined Resident #1 was not interviewable. Refer to the telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm. Refer to the interview with the SIC on 02/29/24 at 4:45pm. Refer to the interview with the Co-Administrator on 02/29/24 at 5:08pm. 2. Review of Resident #3's current FL-2 dated 09/13/23 revealed diagnoses a. Review of Resident #2's current FL-2 dated 09/13/23 revealed an order for FSBS twice weekly. Review of Resident #2's medication administration record (MAR) for December 2023, January 2024, and February 2024 revealed: -There was an entry for FSBS checks twice daily scheduled at 8:00am and 8:00pm. -There was documentation that Resident #2's FSBS was checked twice daily at 8:00am and 8:00pm. Review of Resident #2's FSBS log revealed there was documentation Resident #2's FSBS was checked twice daily. Review of Resident #2's physician's orders revealed no documentation the PCP was contacted to clarify the discrepancy in the order	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
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NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379
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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)	COMPLETE DATE
C 315	Continued From page 16 compared to the MARs. Interview with Resident #2 on 02/29/24 at 8:07am revealed: -He checked his FSBS twice a day. -He thought he was supposed to check his FSBS twice a day. -He wished he did not have to check his FSBS "every day." Interview with the SIC on 02/29/24 at 8:05am revealed Resident #2 was diabetic and had FSBS twice daily but did not take insulin. Second interview with the SIC on 02/29/24 at 4:45pm revealed she did not see the order for Resident #2's FSBS to be checked twice weekly on the FL-2 dated 09/13/23. Interview with the Co-Administrator on 02/29/24 at 5:28pm revealed he did not see the order for Resident #2's FSBS to be done twice a week on the FL-2 dated 09/13/23. Telephone interview with Resident #2's PCP on 02/29/24 at 2:06pm revealed: -Resident #2 did not need to have his FSBS checked twice a day. -If she signed the FL-2 with an order for an FSBS it was in error. -She would have expected the facility staff to have clarified the order. Refer to the telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm. Refer to the interview with the SIC on 02/29/24 at 4:45pm. Refer to the interview with the Co-Administrator	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL 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)	COMPLETE DATE
C 315	Continued From page 17 on 02/29/24 at 5:08pm. b. Review of Resident #2's current FL-2 dated 09/13/23 revealed an order for Advair (used to treat COPD) 250/50 inhale one puff every 12-hours as needed (PRN). Review of Resident #2's medication administration record (MAR) for December 2023 revealed: --There was an entry for Advair 250/50 inhale one puff twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Advair was administered twice a day at 8:00am and 8:00pm 12/01/23-12/31/23. Review of Resident #2's MAR for January 2024 revealed: -There was an entry for Advair 250/50 inhale one puff twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Advair was administered twice a day at 8:00am and 8:00pm from 01/01/24-01/31/24. Review of Resident #2's MAR for February 2024 revealed: -There was an entry for Advair 250/50 inhale one puff twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Advair was administered twice a day at 8:00am and 8:00pm from 02/01/24-02/28/24 and the 8:00am dose on 02/29/24. Review of Resident #2's physician's orders revealed no documentation the PCP was contacted to clarify the discrepancy in the order	C315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL 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)	COMPLETE DATE
C 315	Continued From page 18 compared to the MARs. Telephone interview with a pharmacy technician on 02/29/24 at 1:13pm revealed: -Resident #2's original order for Advair 250/50 was from 01/27/23. -Resident #2's Advair order was always for twice daily and had never been PRN. -Resident #2's Advair was dispensed on 01/09/24, 02/03/24, and 02/28/24, each with directions for twice daily. Interview with Resident #2 on 02/29/24 at 4:03pm revealed he used his inhaler twice a day. Telephone interview with Resident #2's PCP on 02/29/24 at 2:06pm revealed: -She had not made any changes to Resident #2's Advair frequency. -If the order on the FL-2 was different than what the resident had been taking, she would have expected the facility staff to have clarified the order. Interview with the SIC on 02/29/24 at 4:45pm revealed: -She administered Resident #2's Advair twice daily. -She did not see the order for Resident #2's Advair to be administered PRN. Interview with the Co-Administrator on 02/29/24 at 5:28pm revealed he did not see the PRN order for Resident #2's Advair on the FL-2 dated 09/13/23. Refer to the telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm. Refer to the interview with the SIC on 02/29/24 at.	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
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C 315	Continued From page 19 4:45pm. Refer to the interview with the Co-Administrator on 02/29/24 at 5:08pm. 3. Review of Resident #3's current FL-2 dated 09/13/23 revealed: -Diagnoses included hypertension and a history of stroke (3 years ago). -There was an order for blood pressure checks twice daily. Review of Resident #3's medication administration record (MAR) for December 2023, January 2024, and February 2024 revealed: -There was no entry for BP checks for Resident #3. -There was no documentation on the front or back of the MAR for BP readings for Resident #3. Review of Resident #3's physician's orders revealed no documentation the PCP was contacted to clarify the discrepancy in the order. Telephone interview with a pharmacy technician on 02/29/24 at 1:13pm revealed: -She did not have an order to check Resident #3's BPs twice daily. -If the facility had an order to check Resident #3's BP, the order should be sent to the pharmacy; the pharmacy would have put BP checks on Resident #3's MAR if the order was received. Interview with Resident #3 on 02/29/24 at -He did not have his BP checked by facility staff. -His doctor checked his BP, but no one else checked it. -He did not know if his BP was supposed to be checked or not.	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
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C 315	Continued From page 20 - Interview with the SIC on 02/29/24 at 8:05am revealed there were no residents who had ordered BP checks. Second interview with the SIC on 02/29/24 at 4:45pm revealed: -She did not check Resident #3's BP twice daily. -She did not see the order for Resident #3's BP checks on the FL-2 dated 09/13/23. Interview with the Co-Administrator on 02/29/24 at 5:28pm revealed he did not see the order for Resident #3's twice daily BP checks on the FL-2 dated 09/13/23. Telephone interview with Resident #3's PCP on 02/29/24 at 2:06pm revealed: -Resident #3's BP had not been elevated when she checked his BP, and she did not think the resident needed his BP checked twice a day. -If there was an order on Resident #3's FL-2 to check his BP twice a day, it was an error. -She would have expected the facility staff to have clarified the order. Refer to the telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm. Refer to the interview with the SIC on 02/29/24 at 4:45pm. Refer to the interview with the Co-Administrator on 02/29/24 at 5:08pm. Interview with the SIC on 02/29/24 at 4:45pm revealed: -She compared the new FL-2 to the residents' old FL-2 and the current MARs. -If information on the new FL-2 did not match she would contact the Co-Administrator.	C 315		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017066	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/29/2024
NAME OF PROVIDER OR SUPPLIER JEFFERSON CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
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C 315	Continued From page 21 -She did not recall seeing any information on the FL-2s completed on 09/13/23 that did not match and therefore did not call the Co-Administrator. Telephone interview with Resident #1's PCP on 02/29/24 at 2:06pm revealed she did not complete FL-2s for the residents and depended on the facility staff to provide her with an updated FL-2 that reflected the residents' current orders for her to review and sign. Interview with the Co-Administrator on 02/29/24 at 5:08pm revealed: -He thought the PCP completed the FL-2s. -He was responsible for reviewing FL-2s when they were completed. -He reviewed the FL-2s to look for new orders and/or changes. -He was responsible for comparing the new FL-2s to the residents' current MARs. -The SIC could review the FL-2s for any changes, but ultimately, he was responsible for reviewing..	C 315		