Division of Health Service Regulation

Received via email on 10/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	PCI 017000	A. BUILDING _____ B. WING _____	R 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRY CARE HOME	8448 CHERRY GROVE ROAD VANDEMERE, NC 27979

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)	COMPLETION DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a follow-up survey on 09/11/24 to 09/12/24 with an exit conference via telephone on 09/12/24	C 000	THE CHILD WAS NOT RESIDING AT THE FACILITY, WAS THERE SPORADICALLY, AND WAS NOT AFFECT SERVICES TO THE FACILITY RESIDENTS. TRAINING WITH THE SIC AND FACILITY STAFF WILL BE DONE REGARDING THE PROVISION OF PCS AND ATTENDING TO THE RESIDENT'S NEEDS IN A TIMELY AND APPROPRIATE MANNER. THIS WILL BE MONITORED BY Admt Owner on a weekly bases.	10/01/2024
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the	C 007		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Owner.	10/9/2024 Bonnie Mcafee, RN Admin	

Reviewed and acknowledged on 10/18/24. PD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017009	A. BUILDING: _____ B. WING _____	R 09/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 1 Division of Health Service Regulation for review of any possible changes that may be required to the building. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to maintain the licensed capacity of five residents with the addition of a child who was residing in the home. The findings are: Review of the facility license revealed the facility was licensed for a capacity of 5 residents; including 3 non-ambulatory reidents. Observation of the facility on 09/11/24 at 8:10am revealed: -There were five residents, one non-resident and the Supervisor-in-Charge (SIC) living in the facility. -There was a child in a small play pen in a room off the kitchen. Observations of the SIC on 09/11/24 from 8:15am to 4:30pm revealed: -She would go into the room next to the kitchen and close the door. -The residents would knock on the door when they needed her.	C 007		

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	FCL017008	A. BUILDING: _____ B. WING _____	R 09/12/2024

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

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C 007	Continued From page 2 -She came in and out of the room to prepare meals. -At 3:30pm the SIC went into the room with the child and closed the door until 3:40pm. Interview with a resident on 09/11/24 at 8:35am revealed: -She needed help with washing her feet but could not get the staff to help her. -The SIC did not have time to help her or give her a shower. -The SIC took care of a child. -The child was at the facility from Friday to Monday 24 hours a day, day and night. Interview with a second resident on 09/12/24 at 8:50am revealed there was a child at the facility once a week for a couple of days at a time and overnight. Interview with a third resident on 09/11/24 at 9:20am revealed: -There was a child that stayed at the facility all the time. -The SIC was always taking care of the child. -The SIC did not have time to take care of the residents because she was busy taking care of the child. Interview with a fourth resident on 09/11/24 at 11:14pm revealed: -The SIC used to help him with his showers but she stopped. -The child was at the facility all week. -He could hear it cry at night. -The SIC was supposed to watch the residents but she was always watching the child. Interviews with the SIC on 09/11/24 at 8:32am and 10:15am revealed:	C 007		

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TERRY CARE HOME	2448 CHERRY GROVE ROAD YANCEYVILLE, NC 27379

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C 007	Continued From page 3 -The child had been at the facility since Friday, 09/06/24. -The child was supposed to be picked up on Monday but was still at the facility. -The child came to the facility every Friday and stayed until Monday. -The child had been staying at the facility every weekend for about one year. -The child was not two years old yet. -She could take care of the residents and the child. -The Administrator knew the child was staying at the facility. Telephone interview with the Administrator on 09/11/24 at 5:20pm revealed: -She knew the SIC was watching the child today, 09/11/24 because there was an emergency yesterday or the day before. -She was not aware until today, 9/11/24 that the SIC had been watching the child. -She knew the child had been there before, but she did not know she was spending the night. -She did not consider it an issue because it was an adult care home and the child was not a resident. -She did not know how much time was spent taking care of the child she could not put a number on it. -She would guess the SIC spent an hour and a half to two hours per day taking care of the child. -She did not feel having the child at the facility interfered or took away from the residents' care. -The SIC was ultimately responsible for the residents' care. The facility failed to ensure the census remained at the license level of five residents by allowing a child to reside in the facility, which prevented the SIC from providing personal care to the residents	C 007		

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C 007	Continued From page 4 and attending to the residents' needs. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/12/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 27, 2024	C 007		
C 242	10A NCAC 13G .0901(a) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care and Supervision (a) Family care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide personal care assistance to 1 of 3 sampled residents (#1) including dressing and bathing. The findings are: Review of Resident #1's current FL-2 dated 01/01/24 revealed diagnoses included syncope, bradycardia, hypertension, anemia, renal insufficiency and heartburn.	C 242		

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C 242	Continued From page 5 Review of Resident #1's Care Plan dated 01/01/24 revealed there was documentation she was totally dependent on dressing, bathing, grooming and toileting. Observation of Resident #1 on 09/11/24 at 8:32am revealed she was wearing a stocking hat, white sweatpants, a blue top, gray socks and lace up tennis shoes. Observation of Resident #1 on 09/12/24 at 8:26am revealed she was wearing white sweatpants, a blue top, gray socks and lace up tennis shoes. Review of Resident #1's after visit report from the hospital dated 09/06/24 revealed: -Resident #1 visited the local emergency department on 09/06/24 due to complaint of lower right leg pain. -She was discharged from the hospital on 09/06/24 and returned to the facility. Interviews with Resident #1 on 09/11/24 at 8:35am and 10:20am revealed: -She had bad sciatica pain in her hip that ran down to her calve. -She had recently been to the hospital for the pain. -She could not bend over due to the pain. -She could not remove her shoes and socks without help because of the pain. -She needed help with washing her feet but could not get the Supervisor-in-Charge (SIC) to help her. -She did not want to bother the SIC because she knew she did not have time to help her remove her shoes and socks. -She had been sleeping in her shoes and socks since she returned from the hospital a few days	C 242		

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C 242	Continued From page 6 ago. -Her foot was itchy and felt swollen inside her shoe. -The last time her shoes were off was at the hospital. -She could not bend over to remove her socks and shoes. -She did not take a bath or a shower; she took a "washup" while sitting in the bathroom on the closed toilet seat. -The SIC was so busy she stopped giving her showers and started giving her a washup. -The last time she had a shower was a long time before she went to the hospital. -She would pull her adult briefs off over her shoes and socks while they were still on. Interview with the SIC on 09/11/24 at 4:10pm revealed: -She helped Resident #1 with her bath by washing her legs and her back. -Resident #1 would sit on the toilet and she would wash herself. -Resident #1 could bend over at the waist. -Sometimes she could dress herself and sometimes she could not. -She could put on her own shoes and socks by herself. -Sometimes Resident #1 would help herself but she never complained she needed help to get dressed or bathed. -Since Resident #1 returned from the hospital she had been helping the resident with her clothes every day. -Resident #1 could put her socks and shoes on by herself and had been putting them on by herself since she returned from the hospital. -She knew Resident #1 had been putting her shoes and socks on herself because she came out of her room with them on every morning.	C 242	THE RESIDENT DID NOT MAKE STAFF AWARE OF NEEDS WITH ASSISTANCE REMOVING SOCKS OR SHOES AFTER COMING HOME FROM HOSPITAL. THE RESIDENT REFUSED ASSISTANCE WITH REMOVING HER SHOES AND SOCKS WHEN OFFERED ASSISTANCE.THE STAFF OFFERED SLIP ON SHOES TO RESIDENT TO MAKE IT EASIER TO PUT ON AND TAKE THEM OFF, AND RESIDENT REFUSED. THE RESIDENT;S CARE PLAN HAS BEEN REVISED AND SIGNED BY NP. THE STAFF WILL BE PROVIDED TRAINING IN DOCUMENT CHANGES IN CONDITION AND REFUSALS TO ACCEPT ASSISTANT CARE. THIS WILL BE MONITORED BY Adm+owner on a weekly bases.	10/25/24

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C 242	Continued From page 7 -Resident #1 had not told her she needed help removing or putting on her shoes and socks. -She was not aware Resident #1 had been sleeping in her shoes at night. -She had never told Resident #1 she was too busy to help her. -Resident #1 preferred not to get a full shower but to "washup". -She had given Resident #1 a washup on 09/09/24; she took the resident's shoes and socks off and put them back on for her. -If Resident #1 had told her about her shoes she would have helped her; the resident should have told her she was sleeping in her shoes. Interview with Resident #1's primary care provider (PCP) on 09/11/24 at 1:30pm revealed: -Resident #1 had hip pain from an old hip injury. -He did not know Resident #1 was unable to remove her shoes due to pain. -He could do a referral for physical therapy to help her with her socks and shoes. -He could not recall Resident #1's care plan if she required extensive assistance or was totally dependent for dressing and bathing. -Resident #1 would require assistance from staff with bathing and dressing if her care plan had her needs as totally dependent for dressing, grooming and bathing. Interview with the Administrator on 09/11/24 at 4:55pm revealed: -None of the residents were totally dependent on the staff for toileting, bathing, grooming or dressing. -Resident #1 sometimes needed assistance once she was in the shower or needed assistance getting clothes on and off. -Resident #1 did not require assistance with bathing and dressing on a regular basis.	C 242		

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C 242	Continued From page 8 -Resident #1 had not complained about not taking her shoes and socks off since her hospital visit. -She did not understand why Resident #1 did not let the SIC know she could not take her shoes and socks off. -The SIC probably was not aware there was an issue with Resident #1's shoes and socks because the resident would come out in the morning with them on her feet. -She was not aware Resident #1 was not taking a full bath. -Resident #1's care plan was not accurate and needed updating; She was not totally dependent on showering, toiling, grooming and dressing. -She was not sure who had completed Resident #1's care plan. -Resident #1 should have let the SIC know she could not take her shoes and socks off. -The SIC was ultimately responsible for the residents' care. The facility failed to ensure the personal care needs were met for a resident (#1) who had been sleeping with her shoes and socks on for five days who could not remove her shoes and socks herself due to hip pain and was totally dependent for assistance with dressing and bathing. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/12/24 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 27, 2024	C 242		

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C 246	Continued From page 9	C 246	~~THE FACILITY SCHEDULED AN~~ APPOINTMENT WITH THE PODIATRIST, THE WEEK AFTER THE SURVEY. RESIDENT"S NP HAD NEVER HEARD ABOUT ANY COMPLAINTS ABOUT FEET OR NAIL CARE IN THE TWO YEARS PRACTITIONER HAD SEEN RESIDENT. THE RESIDENT IS ALSO NOT A DIABETIC AND DID NOT REQUIRE PERIODIC INSPECTIONS OF RESIDENT'S FEET. THE TREATING PRACTITIONER CONCLUDED THAT THE RESIDENT HAS "HAMMER TOES" THAT OCCUR FOR A VARIETY OF REASONS AND NOT CONSTITUTE A RISK TO THE RESIDENTS HEALTH. THE RESIDENT HAS HAD THIS CONDITION FOR MANY YEARS BUT THAT HE MANAGES WITHOUT THERAPY OR TREATMENT. THE RESIDENT HAS POOR FOOT HYGIENE AND THAT HIS CARE PLAN WILL BE REVISED TO FOCUS ON ASSISTANCE WITH FOOT CARE. THE STAFF WILL BE PROVIDED TRAINING IN DCUMENT CHANGES IN CONDITION AND HEALTHCARE REFERRAL AND FOLLOW UP. THIS WILL BE MONITORED BY Adm+Owner on a weekly bases	10/12/24
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: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral to a podiatrist for 1 of 3 sampled residents (Resident #3) related to a foot care. The findings are: Review of Resident #3's FL-2 dated 10/23/23 revealed diagnoses included schizophrenia, hepatic cirrhosis, and hypertension. Review of Resident #3's record revealed there was no information from a podiatrist appointment. Review of Resident #3's care plan dated 10/23/23 revealed he required limited assistance with bathing, dressing and grooming. Observation of Resident #3 on 09/11/24 at 9:02am revealed: -His fingernails on his left and right hands were a quarter of an inch past the tip of his finger on eight of his 10 fingers and were uneven. -There was a thick brown substance built up under the longer fingernails. -There was scaly, flaking, pealing and was discolored skin on the top of his left and right foot. -There were multiple large patches of thick peeling skin on the bottom of his feet and toes. -There was a buildup of dark colored debris and	C 246		

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C 246	Continued From page 10 dried skin under and between his toes on the bottom of his left and right foot. -There were two calluses on the bottom of his right foot. -There was a thick callus in the center of the ball of his right foot that was the size of a quarter with layers of skin peeling at the edges. -There was a second callus on his right foot at the ball of his big toe that had thick skin and dark discoloration in the center with small discolored places and small brown circles of peeling skin surrounding it. -The toenails on his left and right foot were thick, ruff, jagged and discolored. -The second toenail next to his big toe on his left foot was long and slightly curved towards the middle toe and had lint and debris under it. -The middle and fourth toenails on his left foot extended past the end of his toe one-eigth inch to one-fourth inch. -The middle and forth toenails on his right foot extended past the end of his toe one eight to one fourth inch. Interviews with Resident #3 on 09/11/24 at 9:00am and 1:14pm revealed: -He cut his own fingernails. -His toenails were cut about once a year by a physician. -His toenails were "worse" than his fingernails. -His feet hurt. -He could not wash between his toes himself; he needed help from staff. -If he could get a washcloth between his toes, he could get all the "dirt" out. -He told the Supervisor-in-Charge (SIC) he needed help cleaning his feet. -The SIC would not wash his feet for him; she would give him a "hard time" about washing his feet.	C 246		

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C 246	Continued From page 11 -It felt like he was walking on rocks without shoes when he walked. -He walked "real slow" because it hurt to walk. -A physician had looked at his feet and cut his toenails once since he had been at the facility. -He did not tell the SIC, his physician or the Administrator about his feet hurting because he did not want to bother anyone. Interview with Resident #3's primary care provider (PCP) on 09/11/24 at 1:30pm revealed: -Resident #3 had not complained of foot pain to him. -He had not had a reason to look at Resident #3's feet because he was told by the resident everything was good. -The residents at the facility were seen by a podiatrist. -He did not know if the residents were seen by the podiatrist regularly or as needed. Interview with representative from the facility's contracted podiatry office on 09/12/24 at 1:32pm revealed: -Resident #3 was seen by the podiatrist at the facility on 01/23/24. -His toenails were cut and his calluses were filed. -The facility had reached out the day before, on 09/11/24 for an appointment to see Resident #3. Interviews with the SIC on 09/11/24 at 2:10pm and 4:20pm revealed: -The podiatrist came to the facility and saw all the residents every three months. -The podiatrist cut all the residents' toenails. -The podiatrist did not leave any reports when they visited the residents. -She could not recall the last time the podiatrist was at the facility. -The Administrator scheduled the podiatry	C 246		

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C 246	Continued From page 12	C 246		

appointments.
-Resident #3 did not complain of any foot pain to her.
-She had not looked at Resident #3's feet.
-She had not seen his feet or looked at them in a while.
-She only did skin assessments for the residents after a hospital return or when they were admitted to the facility.
-Resident #3 should have told her about his toenails and his feet; she would have told the Administrator about them.
-She had never cut Resident #3's fingernails.
-She used to ask him about his nails but could never get a straight answer because he would walk away.
-she cut other residents' fingernails when she noticed they were long.

Interview with the Administrator on 09/11/24 at 4:55pm revealed:
-The last time the podiatrist was at the facility was in January 2024 and all the residents were seen.
-The staff could cut the residents toenails unless they were diabetic.
-The staff persuaded all the residents to be seen by the podiatrist when they visited the facility.
-Resident #3 was seen by the podiatrist in January 2024.
-Resident #3 had not complained of foot pain when she saw him.
-She had seen Resident #3 on Friday, 09/06/24.
-She had noticed his fingernails could be long on occasion, but he was comfortable with it and did not want his fingernails cut.
-She had asked him about his finger nails about two weeks ago when she noticed they needed to be cut and washed, but he did not want anything done to them at the time.
-The SIC was ultimately responsible for the

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	FCL017009	A. BUILDING: _____ B. WING _____	R 09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRY CARE HOME	2448 CHERRY GROVE ROAD YANCEYVILLE, NC 27379

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C 246	Continued From page 13 residents' care. The facility failed to ensure a referral and follow up for a resident (#2) who had not been seen by a podiatrist in over six months and who had long thick toenails, dry feet, buildup of skin and debris between his toes and calluses on both feet (#3) and who complained of pain when walking. This failure resulted in significant risk for harm and pain which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/12/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 12, 2024	C 246	Training will be provided by pharmacy and B. McGee,RN on medication administration and documentation. Medications were administered as ordered but staff just didn't document she administered the meds. Staff was informed this can not continue. She is very aware of her mistake. This will be monitored on a weekly bases. MEDICATIONS WILL BE SIGNED FOR AFTER MEDICATIONS ARE GIVEN. THIS WILL BE MONITORED BY Admt Owner on a weekly bases	10/30/24
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the recording of the	C 341		

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C 341	Continued From page 14	C 341		

administration of medication on the medication administration record immediately following administration of the medication to the resident for 3 of 3 residents (#1, #2, and #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 01/01/24 revealed:
-Diagnoses included Syncope, bradycardia, hypertension, anemia, renal insufficiency and heartburn.
-There was an order for amlodipine (used to treat high blood pressure) 5mg one daily.
-There was an order for furosemide (used to treat edema) 40mg once daily.
-There was order for trazadone (used to treat depression) 100mg once daily.
-There was an order for Olmesartan (used to treat high blood pressure) 40mg once daily
-There was an order for potassium chloride (used to treat hypokalemia) 20mg once daily.
-There was on order for montelukast (used to treat allergies) 10mg once daily.

Review of Resident #1's medication administration record (MAR) for September 2024 from 09/01/24 to 09/11/24 revealed:
-There was an entry for amlodipine 5mg once daily scheduled at 8:00am; amlodipine was not documented as administered on 09/11/24 at 8:00am.
-There was an entry for furosemide 40mg once daily scheduled at 8:00am; furosemide was not documented as administered on 09/11/24 at 8:00am.
-There was an entry for trazadone 100mg once daily scheduled at 8:00pm; trazadone was not documented as administered on 09/10/24 at 8:00pm.

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C 341	Continued From page 15 -There was an entry for Olmesartan 40mg scheduled at 8:00am; Olmesartan was not documented as administered on 09/11/24 at 8:00am. -There was an entry for potassium chloride 20mg scheduled at 8:00am; potassium chloride was not documented as administered on 09/11/24 at 8:00am. -There was an entry for montelukast 10mg scheduled at 8:00am; montelukast was not documented as administered on 09/11/24 at 8:00am. Interview with Resident #1 on 09/11/24 at 8:35am revealed the medication aide (MA) had administered her medications yesterday, on 09/10/24 and today, 09/11/24. Refer to the interview with the MA on 09/11/24 at 8:18am. Telephone interview with the Administrator on 09/11/24 at 5:20pm. 2. Review of Resident #2's FL-2 dated 05/06/24 revealed: -Diagnoses included diabetes mellitus two, lower back pain, schizophrenia, spine surgery, and chronic obstructive pulmonary disease (COPD). -There was an order for clonazepam (used to treat anxiety) 0.5mg twice daily. -There was an order for melatonin (used to treat delayed sleep) 5mg once daily. -There was an order for tamsulosin (used to treat enlarged prostate) 0.4mg once daily. -There was an order for methocarbamol (used to treat muscle spasms and pain) 750mg three times daily. Review of Resident #2's medication	C 341		

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C 341	Continued From page 16 administration record (MAR) for September 2024 from 09/01/24 to 09/11/24 revealed: -There was an entry for clonazepam 0.5mg twice daily scheduled at 8:00am and 12:00pm; clonazepam was not documented as administered on 09/10/24 at 12:00pm and 8:00am on 09/11/24. -There was an entry for melatonin 5mg once daily scheduled at 8:00pm; melatonin was not documented as administered on 09/10/24 at 8:00pm. -There was an entry for tamsulosin 0.4mg once daily scheduled at 8:00am; tamsulosin was not documented as administered on 09/11/24 at 8:00am. -There was an entry for methocarbamol 750mg three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -Methocarbamol was not documented as administered on 09/10/24 at 2:00pm and 8:00pm and on 09/11/24 at 8:00am. Interview with Resident #2 on 09/11/24 at 9:10am revealed the medication aide (MA) had already administered him his morning medication today, on 09/11/24 and she administered his medications the day before on, 09/10/24. Refer to the interview with the MA on 09/11/24 at 8:18am. Telephone interview with the Administrator on 09/11/24 at 5:20pm. 3.Review of Resident #3's FL-2 dated 10/23/23 revealed: -Diagnoses included schizophrenia, hepatic cirrhosis, hepatitis C, hypertension and cocaine abuse. -There was an order for amlodipine (used to treat	C 341		

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C 341	Continued From page 17 high blood pressure) 5mg one daily. -There was an order for atorvastatin (used to treat high cholesterol) 20mg once daily. -There was an order for losartan (used to treat high blood pressure) 100mg once daily. -There was an order for clonazepam (used to treat anxiety) 1mg twice daily. -There was an order for divalproex (used to prevent seizures) 500mg twice daily. Review of Resident #3's medication administration record (MAR) for September 2024 from 09/01/24 to 09/11/24 revealed: -There was an entry for amlodipine 5mg once daily scheduled at 8:00am; amlodipine was not documented as administered at 8:00am on 09/11/24. -There was an entry for losartan 100mg once daily scheduled at 8:00am; losartan was not documented as administered at 8:00am on 09/11/24. -There was an entry for clonazepam 1mg twice daily scheduled at 8:00am and 8:00pm; clonazepam was not documented as administered at 8:00pm on 09/10/24 and 8:00am on 09/11/24. -There was an entry for divalproex 500mg twice daily scheduled at 8:00am and 8:00pm; divalproex was not documented as administered at 8:00pm on 09/10/24 and 8:00am on 09/11/24. Interview with Resident #3 on 09/11/24 at 9:00am revealed the medication aide (MA) had administered his medications the day before, on 09/10/24 and today, 09/11/24 at breakfast. Refer to the interview with the MA on 09/11/24 at 8:18am. Telephone interview with the Administrator on	C 341		

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C 341	Continued From page 18 09/11/24 at 5:20pm. _____ Interview with the medication aide (MA) on 09/11/24 at 8:18am revealed: -She had not documented in the medication administration record (MAR) yet because she was cleaning up breakfast. -She would document in the MAR after she had cleaned everything up and had time. -She had not documented after breakfast the day before because she had gotten busy and forgotten about it. -She knew she was supposed to document on the MAR after administering each resident their medication. Telephone interview with the Administrator on 09/11/24 at 5:20pm revealed: -She was responsible for monitoring and auditing the MAR. -She looked at the MAR weekly. -The MAR was always complete when she looked at it. -The MA's were trained to administer the medication to the residents one at a time and then document on the MAR immediately after administering the medication.	C 341		