

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 10/07/2024
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 and the Caswell County Department of Social Services conducted an annual and follow-up survey on 10/07/24.	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 1 of 3 exit doors that were accessible to one resident, who was intermittently disoriented (#4) had a working alarm that was of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Observation of the three exit doors, on the front, and two sides of the facility, on 10/07/24 at various times between 8:00am-5:00pm revealed; -The residents went in and out of a door on the right side of the facility throughout the day.	C 069		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

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C 069	Continued From page 1 -No alarm sounded when this door was opened and closed. -There was an alarm attached to the door. -The alarm did not make an audible sound when the door was opened. -The other two exit doors both had alarms that made an audible sound when the door was opened. Interview with three residents on 10/07/24 between 8:00am-5:00pm revealed: -One resident stated the alarm worked on the door sometimes, but not all the time; "maybe the battery had given out or something." -A second resident stated, that some days the door alarm worked and some days the door alarm did not work. -A third resident stated, she last heard the door alarm about three weeks ago. Review of Resident #4's current FL-2 dated 08/02/24 revealed: -Diagnoses included schizoaffective disorder, narcissistic personality disorder, and schizophrenia. -The resident was intermittently disoriented. Review of Resident #4's Resident Register revealed an admission date of 05/06/16. Review of Resident #4's assessment and care plan dated 07/25/23 revealed: -This care plan was the most recent care plan in the resident's record. -The resident was sometimes forgetful and needed reminders. -The resident was sometimes disoriented. Interview with a Supervisor In Charge (SIC) on 10/07/24 at 9:35am revealed:	C 069		

Division of Health Service Regulation

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C 069	Continued From page 2 -Resident #4's memory was good, but the resident lived in an imaginary world. -There were door alarms on all the doors. -The alarm on the end door (on the right side of the facility) had been de-activated because the alarm would not shut off. -She thought it was deactivated about a week and a half ago. -The Administrator was aware of the door alarm not working correctly. -The door alarm had been fixed several times. Interview with the Administrator on 10/07/24 at 3:56pm revealed: -Door alarms were in place on the doors to alert staff when a resident went outside. -There were no residents who had been identified as a wanderer at the facility. -He did not know if any residents were intermittently disoriented or not without looking at the residents' records. -He was not aware of the alarm on the end door not working. Telephone interview with Resident #4's primary care provider's (PCP) on 10/07/24 at 4:23pm revealed: -She would consider Resident #4 to be intermittently disoriented. -She had not had any reports of Resident #4 wandering away from the facility.	C 069		
C 079	10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (6) have supply of bath soap, clean towels,	C 079		

Division of Health Service Regulation

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C 079	Continued From page 3 washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This rule apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure toilet paper, soap, and clean towels were available for 5 of 5 residents use in the bathroom used by the residents. The findings are: Observation of the hallway bathroom during the initial tour 10/07/24 at 8:23am revealed: -There was no hand soap in the bathroom. -There were no hand towels or paper towels in the bathroom. -There was no toilet paper in the bathroom. -There was a plastic container sitting on the floor beside the toilet. Interview with a resident on 10/07/24 at 8:27am revealed: -There was no hand soap in the bathrooms to use. -She took her own hand soap and towel to the bathroom. Interview with a second resident on 10/07/24 at 1:34pm revealed: -Residents had to ask for toilet paper before going to the bathroom. -She tried to take her own toilet paper to the bathroom but sometimes she forgot. -She had been to the bathroom before and forgot to ask for toilet paper. -Sometimes the bathroom had soap to wash her hands.	C 079		

Division of Health Service Regulation

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C 079	Continued From page 4 Observation of a resident on 10/07/24 at 11:10am revealed: -The resident entered the hallway bathroom. -When the resident exited the hallway bathroom she returned to her room. Observation of the hallway bathroom on 10/07/24 at 11:14am revealed: -There was no toilet paper in the bathroom available to be used. -There was no hand soap, or paper towels available to be used. Interview with the resident on 10/07/24 at 11:14am and 4:58pm revealed: -She had "just used the bathroom." -There was no toilet paper in the bathroom. -She used her washcloth to clean herself after using the bathroom. -She washed the washcloth out and hung the washcloth on her closet door. -She reused her washcloth. -She had forgotten to take her washcloth to the bathroom before and had to go to the bathroom door and ask staff for toilet paper. -Toilet paper was kept in the office because some residents used too much toilet paper. Telephone interview with an Environmental Health Specialist with the local health department on 10/07/24 at 12:15pm revealed: -Resident bathrooms should always have toilet paper, hand soap, and paper towels in the bathroom. -Toilet paper would be more sanitary to use over washcloths. -If the facility did not have and use proper supplies it would increase the risk of spreading fecal matter.	C 079		

Division of Health Service Regulation

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C 079	Continued From page 5 Interview with an Administrator on 10/07/24 at 3:32pm revealed there should be toilet paper, soap, and paper towels in the bathroom at all times. Third observation of the hallway bathroom on 10/07/24 at 12:40pm revealed: -There was toilet paper in the bathroom. -There was no soap or hand towels in the bathroom. Interview with the second Administrator on 10/07/24 at 3:44pm revealed: -Bathrooms should be supplied with toilet paper, soap, hand sanitizer, and paper towels. -Residents should not be using a washcloth as a substitute for toilet paper. Second interview with the SIC on 10/07/24 at 4:05pm revealed: -When she saw the bathroom did not have toilet paper, paper towels, or soap today, 10/07/24, she put the items in the bathroom. -She could not say what the other SIC did or did not do but when she saw it, she fixed it. Telephone interview with the facility's contracted primary care provider (PCP) on 10/07/24 at 4:23pm revealed: -Residents should have toilet paper, soap, and something to dry their hands on in the bathroom. Attempted telephone interview with a second SIC on 10/07/24 at 2:33pm was unsuccessful.	C 079		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights	C 311		

Division of Health Service Regulation

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C 311	Continued From page 6 A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to ensure residents were treated with respect, consideration, and dignity related to the residents being required to dispose of soiled toilet paper into a plastic container and had to carry the container to an outside trash can due to the facility toilets becoming stopped up and at times having to plunge toilets after having a bowel movement (BM). The findings are: Interview with a resident on 10/07/24 at 8:27am revealed: -The toilets got stopped up quite often. -She had to push BM down the toilet with a plunger every time she had a BM. -The toilets backed up when the facility washed a lot of clothes. -The residents were not allowed to put the toilet paper they used to clean themselves into the toilet. -She had to plunge the toilet on Friday, 10/04/24. -She did not like having to plunge the toilet every time she had a BM. -She had to take her used toilet paper outside for months. -She was putting her toilet paper in a container beside the toilet, but a [named] Supervisor-in-Charge (SIC) told her to carry the toilet paper to the outside trash can. -Once she cleaned herself, she took the toilet	C 311		

Division of Health Service Regulation

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C 311	Continued From page 7 paper outside. -It was "filthy to have to carry the toilet paper up the hall, open the door, and put the toilet paper in the trash can." -She had gone into the bathroom to use the toilet after another resident and the toilet had not been plunged. -She would have to wait until someone plunged the toilet. -She did not know if the Administrator knew the residents were not allowed to put toilet paper in the toilet. Interview with a second resident on 10/07/24 at 8:43am and 5:01pm revealed: -The facility had poor drainage, and the water backed up into the shower. -Residents were told by the SIC to put toilet paper into a plastic container by the toilet and to take the container to an outside trash can. -If she had a BM, the toilet was not going to flush without being plunged. -She recalled having to plunge the toilet last weekend after the storm (09/27/24). -The residents plunged the commodes themselves when they had a BM. -Only one resident was not able to plunge the commode, and she would plunge the commode for that resident. Interview with a third resident on 10/07/24 at 9:00am revealed: -When she urinated, she put the used toilet paper into the container beside the toilet. -Urine flushed fine in the toilet. -When she had a BM, she put the used toilet paper in the container beside the toilet. -She had not had to plunge the toilet "in a while." Interview with a fourth resident on 10/07/24 at	C 311		

Division of Health Service Regulation

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C 311	Continued From page 8 9:08am and 3:02pm revealed: -The staff wanted the residents to put the toilet paper into a container and take the container outside to the trashcan. -Sometimes BMs flushed and sometimes the toilet would need to be plunged. -She had to plunge the toilet last week when it rained a lot. Interview with a fifth resident on 10/07/24 at 1:34pm revealed she thought it was "absurd" that she had to put toilet paper in the plastic container. Interview with the SIC on 10/07/24 at 9:28am revealed: -Used toilet paper was to be put into the container beside the commode and the resident then took the container outside. -One of the [named] residents was not able to take the container outside to be emptied. -The last time she recalled the toilets backing up was about one and a half weeks ago. -Some of the residents who had mental health issues would forget and put toilet paper into the toilet. -Two [named] residents were not able to plunge the toilets on their own. -The Administrator was aware the residents were not putting toilet paper in the toilets because the toilets were backing-up. Telephone interview with an Environmental Health Specialist with the local health department on 10/07/24 at 12:15pm revealed: -Residents in the facility should be able to lead a normal life without having to worry if the toilet was going to back up when they used the bathroom. -He did not think putting used toilet paper into a plastic container was sanitary. -Used toilet paper should be flushed down the	C 311		

Division of Health Service Regulation

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C 311	Continued From page 9 toilet. -Toilet paper would be more sanitary to use over washcloths. -If the facility did not have and use proper supplies it would increase the risk of spreading fecal matter. Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She did not know anything about the residents putting toilet paper into a container in the bathroom. -She knew at one time there were a couple of residents who were putting too much toilet paper into the toilet causing the toilet to back up. -Used toilet paper should be put in the toilet. -The only thing that should be placed in a container in the bathroom was paper towels. -Wash cloths should not be used in the place of toilet paper. -She would not use a washcloth, and she absolutely would not expect a resident to do this. Interview with the second Administrator on 10/07/24 at 3:44pm revealed: -Toilet paper should go into the toilet. -He had not told staff to tell the residents to put toilet paper into a container and not the toilet. -The residents should not be putting used toilet paper into a container. -Residents should not be using a washcloth as a substitute for toilet paper. Telephone interview with the facility's contracted primary care provider (PCP) on 10/07/24 at 4:23pm revealed: -Toilet paper should be flushed in the toilet. -Not flushing toilet paper down the toilet was "just nasty." -Used toilet paper, that kind of waste, should not	C 311		

Division of Health Service Regulation

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C 311	Continued From page 10 be put in a container to be carried outside to a trash can, that would be a public health issue. -Wash cloths were to be used for one-time use and not washed out and hung up to dry. -Residents not being able to flush toilet used paper in the toilet was a resident rights issue, "definitely a dignity issue." Attempted telephone interview with a second SIC on 10/07/24 at 2:33pm was unsuccessful. The facility failed to ensure the residents' rights were maintained by requiring the residents to put used toilet paper into a trash can and carry the trash can outside after each time they used the bathroom and to have to plunge a commode after having BMs. 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 10/07/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 21, 2024.	C 311		
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	C 341		

Division of Health Service Regulation

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C 341	Continued From page 11 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 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 07/16/24 revealed: -Diagnoses included hyponatremia, major depression, and mild intellectual disability. -There was an order for Hydroxyzine HCL (an antihistamine) 25mg daily. -There was an order for Melatonin (used to aid in sleep) 3mg, take two tablets at bedtime. -There was an order for Senna (a stool softener) 8.6mg take one tablet at bedtime. -There was an order for Metformin HCL (used to treat diabetes) 1000mg, take one tablet twice daily. -There was an order for Famotidine (used to reduce acid) 20mg twice daily. -There was an order for Aspirin EC (used to reduce the risk of heart attack) 81mg once daily. -There was an order for Loratadine (used to treat allergies) 10mg take one tablet daily. -There was an order for Gabapentin (used to treat nerve pain) 300mg take one tablet three times daily. Review of Resident #1's medication	C 341		

Division of Health Service Regulation

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C 341	Continued From page 12 administration record (MAR) for October 2024 from 10/06/24-10/07/24 revealed: -There was an entry for Hydroxyzine HCL 25mg once daily with a scheduled administration time of 8:00pm. -Hydroxyzine was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Melatonin 3mg, take 2 tablets once daily with a scheduled administration time of 8:00pm. -Melatonin was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Senna 8.6mg once daily with a scheduled administration time of 8:00pm. -Senna was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Metformin HCL 1000mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Metformin was not documented as administered on 10/06/24 at 8:00pm or on 10/07/24 at 8:00am. -There was an entry for Famotidine 20mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Famotidine was not documented as administered on 10/06/24 at 8:00pm or 10/07/24 at 8:00am. -There was an entry for Aspirin EC 81mg once daily with a scheduled administration time of 8:00am. -Aspirin was not documented as administered on 10/07/24 at 8:00am. -There was an entry for Loratadine 10mg once daily with a scheduled administration time of 8:00am. -Loratadine was not documented as administered on 10/07/24 at 8:00am. -There was an entry for Gabapentin 300mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.	C 341		

Division of Health Service Regulation

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C 341	Continued From page 13 -Gabapentin was not documented as administered on 10/06/24 at 2:00pm and 8:00pm or on 10/07/24 at 8:00am. Interview with Resident #1 on 10/07/24 at 8:43am revealed the medication aide (MA) had administered her medications yesterday, 10/06/24, and today, 10/07/24. Attempted telephone interview with the MA on 10/07/24 at 2:33pm was unsuccessful. Refer to the interview with the MA on 10/07/24 at 8:12am and 8:19am. Refer to the interview with the Administrator on 10/07/24 at 3:32pm. 2. Review of Resident #2's current FL-2 dated 08/02/24 revealed diagnoses of schizophrenia, hypothyroidism, and overactive bladder. -There was an order for Oxybutynin (used to treat an overactive bladder) 5mg daily. -There was an order for Miralax (stool softener) 17g in 8 ounces water daily. -There was an order for Desmopressin acetate (used to treat an overactive bladder) 0.2mg, take two tablets at bedtime. -There was an order for Lamotrigine 150mg (used to treat seizures) 150mg, take one tablet at bedtime. -There was an order for Melatonin (used to aid in sleep) 3mg, take one tablet at bedtime. Review of Resident #2's medication administration record (MAR) for October 2024 from 10/06/24-10/07/24 revealed: -There was an entry for Oxybutynin 5mg once daily with a scheduled administration time of 8:00am.	C 341		

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 10/07/2024
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 341	Continued From page 14 - Oxybutynin was not documented as administered on 10/07/24 at 8:00am. -There was an entry for Miralax once daily with a scheduled administration time of 8:00am. -Senna was not documented as administered on 10/07/24 at 8:00am. -There was an entry for Desmopressin acetate, take two tablets at bedtime with a scheduled administration time of 8:00pm. -Desmopressin was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Lamotrigine 150mg once daily with a scheduled administration time of 8:00am and 8:00pm. -Lamotrigine was not documented as administered on 10/06/24 at 8:00pm. -There was an entry for Melatonin 3mg, take 1 tablet once daily with a scheduled administration time of 8:00pm. -Melatonin was not documented as administered on 10/06/24 at 8:00pm. Interview with Resident #2 on 10/07/24 at 9:08am revealed the medication aide (MA) had administered her medications yesterday, 10/06/24 and today, 10/07/24. Attempted telephone interview with the MA on 10/07/24 at 2:33pm was unsuccessful. Refer to the interview with the MA on 10/07/24 at 8:12am and 8:19am. Refer to the interview with the Administrator on 10/07/24 at 3:32pm. 3. Review of Resident #3's current FL-2 dated 07/16/24 revealed: -Diagnoses included Diabetes type 2, chronic obstructive pulmonary disorder, arthritis, and	C 341		

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 10/07/2024
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C 341	Continued From page 15 hypertension. -There was an order for Ziprasidone HCL (used to treat schizophrenia) 40mg twice daily. -There was an order for Cogentin (used to treat tremors) 1mg one tablet twice daily. -There was an order for Prolixin (used to treat schizophrenia) 5mg one tablet twice daily. -There was an order for Gabapentin (used to treat nerve pain) 100mg take two tablets twice daily. Review of Resident #3's medication administration record (MAR) for October 2024 from 10/06/24-10/07/24 revealed: -There was an entry for Ziprasidone HCL 40mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Ziprasidone was not documented as administered on 10/06/24 at 8:00pm or 10/07/24 at 8:00am. -There was an entry for Cogentin 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -Cogentin was not documented as administered on 10/06/24 at 8:00pm of 10/07/24 at 8:00am. -There was an entry for Prolixin 5mg once daily with a scheduled administration time of 8:00am and 8:00pm. -Prolixin was not documented as administered on 10/06/24 at 8:00pm of 10/07/24 at 8:00am. -There was an entry for Gabapentin 100mg, take two tablets twice daily with a scheduled administration time of 8:00am and 8:00pm. -Gabapentin was not documented as administered on 10/06/24 at 8:00pm of 10/07/24 at 8:00am. Interview with Resident #3 on 10/07/24 at 9:00am revealed the medication aide (MA) had administered her medications on 10/06/24 and	C 341		

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 10/07/2024
NAME OF PROVIDER OR SUPPLIER HUMPHREY FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 6245 BURTON CHAPEL ROAD MEBANE, NC 27302		
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C 341	Continued From page 16 today, 10/07/24. Attempted telephone interview with the MA on 10/07/24 at 2:33pm was unsuccessful. Refer to the interview with the MA on 10/07/24 at 8:12am and 8:19am. Refer to the interview with the Administrator on 10/07/24 at 3:32pm. Interview with the MA on 10/07/24 at 8:12am revealed: -She called the residents to the kitchen one at a time to administer the residents' medications. -She administered the residents' medications on 10/06/24 and 10/07/24. -She documented on the resident's MAR after she administered the medications. Observation of the MA on 10/07/24 at 8:19am revealed she was documenting her initials on multiple MARs after she had already administered all the residents' medications. Second interview with the MA on 10/07/24 at 8:19am revealed she was documenting on the all the yellow lines on the MAR because that was the medications she administered this morning, 10/07/24. Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She expected the SIC to match the medications on hand to the MAR before administering medication. -Once the medication was administered, the SIC should immediately document the administration on the MAR. -If the SIC was documenting on the MAR as soon	C 341		

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 10/07/2024
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C 341	Continued From page 17 as the medication was administered, there would have been no errors with the documentation.	C 341		
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 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 ensure the medication administration record (MAR) was accurate for 2 of 3 sampled residents (#1, #2) including the administration of a fast-acting insulin medication(#1) and a supplement and a medication used to treat an overactive bladder (#2).	C 342		

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 10/07/2024
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C 342	Continued From page 18 The findings are: 1. Review of Resident #1's current FL-2 dated 07/16/24 revealed: -Diagnoses included hyponatremia, major depression, and mild intellectual disability. -There was an order for Humalog (fast acting insulin) 5 units, three times daily before meals and 5 units at bedtime if the resident's finger stick blood sugar (FSBS) was greater than 150. Review of Resident #1' August 2024 medication administration record (MAR) from 08/01/24 to 08/31/24 revealed: -There was an entry for Humalog 5 units, three times daily before meals and 5 units at bedtime if the resident's FSBS was greater than 150 with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation that 5 units of Humalog were administered at 8:00pm from 08/01/24 to 08/31/24. Review of Resident #1's August 2024 FSBS log revealed: -Resident #1's FSBS was less than 150 on 08/02/24, 08/05/24, 08/06/24, 08/10/24, 08/14/24, 08/15/24, 08/19/24, 08/22/24, 08/23/24, 08/25/24, 08/26/24, and 08/28/24 at 8:00pm. -There was documentation no Humalog insulin was administered on these dates. Review of Resident #1's September 2024 MAR revealed: -There was an entry for Humalog 5 units, three times daily before meals and 5 units at bedtime if the resident's FSBS was greater than 150 with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation that 5 units of	C 342		

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 10/07/2024
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C 342	Continued From page 19 Humalog were administered at 8:00pm from 09/01/24 to 09/30/24. Review of Resident #1's September 2024 FSBS log revealed: -Resident #1's FSBS was less than 150 on 09/13/24, 09/15/24, and 09/19/24 at 8:00pm. -There was documentation no Humalog insulin was administered on these dates. Review of Resident #1's October 2024 MAR from 10/01/24 to 10/07/24 revealed: -There was an entry for Humalog 5 units, three times daily before meals and 5 units at bedtime if the resident's FSBS was greater than 150 with scheduled administration times of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation that 5 units of Humalog were administered at 8:00pm from 10/01/24 to 10/06/24. Review of Resident #1's October 2024 FSBS log revealed: -Resident #1's FSBS was less than 150 on 10/01/24, 10/02/24, 10/05/24, and 10/06/24 at 8:00pm. -There was documentation no Humalog insulin was administered on these dates. Observation of medications on hand on 10/07/24 at 11:23am revealed there was a vial of Humalog and syringes available to be administered. Interview with the Supervisor-in-Charge (SIC) on 10/07/24 at 4:38pm revealed: -She would not know looking at Resident #1's MAR if she administered 5 units of Humalog at 8:00pm. -She would only know if she administered the Humalog or not based on what she documented	C 342		

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 10/07/2024
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C 342	Continued From page 20 on the facility's FSBS log. -If she did not administer Resident #1's Humalog, she should have circled her initials and documented on the back of the MAR what the exception was. -She "just missed circling her initial." Interview with an Administrator on 10/07/24 at 3:32pm revealed: -If a medication was not administered the SIC, should document the exception on the back of the MAR. -She tried to audit the MARs every other month. -She had not audited the MARs since July 2024. 2. Review of Resident #2's current FL-2 dated 08/02/24 revealed diagnoses of schizophrenia, hypothyroidism, and overactive bladder. a. Review of Resident #2's current FL-2 dated 08/02/24 revealed an order for Vitamin D2 (a supplement) 50,000 units (used as a supplement) once weekly. Review of Resident #2's August 2024 medication administration record (MAR) revealed: -There was an entry for Vitamin D2 50,000 units once weekly with a scheduled administration time of 8:00am. -There was documentation Vitamin D2 50,000 was administered on 08/05/24, 08/10/24, 08/16/24, and 08/20/24. Observation of medication on hand on 10/07/24 at 4:00pm revealed a multi-dose bubble pack with Vitamin D2 50,000 units was only in one bubble pack per week; the Vitamin D2 would be in the bubble pack administered on Mondays. Telephone interview with a representative from	C 342		

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 10/07/2024
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C 342	Continued From page 21 the facility's contracted pharmacy on 10/07/24 at 2:57pm revealed: -Resident #2's Vitamin D2 50,000 units was only dispensed once weekly. -The facility was dispensed 4 weekly packets of medication, and each week only contained one tablet of Vitamin D2 and it was always on the same day to be administered. -She did not know what day the medication would be administered because it depended on what day the medication packet was started at the facility, but it would be the same day every week. Interview with the Supervisor-in-Charge (SIC) on 10/07/24 at 4:38pm revealed: -She did not administer Resident #2's Vitamin D because the medication was not administered on the days she worked. -She had accidentally documented administering Resident #2's Vitamin D one time but she had circled her initials and documented on the back the error. Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She expected the SIC to match the medications on hand to the MAR before administering medication. -Once the medication was administered, the SIC should immediately document the administration on the MAR. -If the SIC was documenting on the MAR as soon as the medication was administered, there would have been no errors with the documentation. Attempted telephone interview with a second SIC on 10/07/24 at 2:33pm was unsuccessful. b. Review of Resident #2's current FL-2 dated 08/02/24 revealed an order Desmopressin (used	C 342		

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 10/07/2024
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C 342	Continued From page 22 to treat an overactive bladder) acetate 0.2mg, take two tablets at bedtime. Review of Resident #5's August 2024 medication administration record (MAR) revealed: -There was an entry for Desmopressin acetate 0.2mg daily with a scheduled administration time of 8:00pm. -There was documentation Desmopressin acetate 0.2mg was administered daily from 08/01/24 to 08/31/24 at 8:00pm. -There was a second entry for Desmopressin acetate 0.2mg daily with a scheduled administration time of 8:00pm. -There was documentation Desmopressin acetate 0.2mg was administered daily from 08/01/24 to 08/31/24 at 8:00pm. Observation of medication on hand on 10/07/24 at 4:00pm revealed a multi-dose bubble pack with Desmopressin Acetate 0.2mg and two tablets were in the bubble pack to be administered at 8:00pm; there were no other Desmopressin on hand. Interview with the Supervisor-in-Charge (SIC) on 10/07/24 at 4:38pm revealed: -She had seen Resident #2's Desmopressin listed on the MAR twice and had questioned it. -The Desmopressin was listed twice because on a different page of the MAR a medication was discontinued, and the pharmacy sent a new MAR. -The new MAR had the Desmopressin listed and the SICs were already documenting on the other page of the MAR that had the medication listed. -She should have marked through one of the entries and documented the entry as a duplicate. -She should not have documented on both entries.	C 342		

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 10/07/2024
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C 342	Continued From page 23 Interview with an Administrator on 10/07/24 at 3:32pm revealed: -She expected the SIC to match the medications on hand to the MAR before administering medication. -If the MAR was not correct the SIC should immediately call the pharmacy to ask for a new MAR to be sent to the facility. -The SICs should not write on the MAR but should have requested a new MAR from the pharmacy, even for a duplicate entry.	C 342			