

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 R 02/21/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON FAMILY 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)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on 02/20/25 with an exit via telephone on 02/21/25.	C 000		
C 015	10A NCAC 13G .0214 Suspension of Admissions 10A NCAC 13G .0214 Suspension of Admissions (a) Either the Secretary or his designee shall notify the domiciliary home by certified mail of the decision to suspend admissions. Such notice will include: (1) the period of the suspension, (2) factual allegations, (3) citation of statutes and rules alleged to be violated, (4) notice of the facility's right to contested case hearing or the suspension. (b) The suspension will be effective when the notice is served or on the date specified in the notice of suspension, whichever is later. The suspension will remain effective for the period specified in the notice or until the facility demonstrates to the Secretary or his designee that conditions are no longer detrimental to the health and safety of the residents. (c) The home shall not admit new residents during the effective date of the suspension. (d) Any action taken by the Division of Facility Services to revoke a home's license or to reduce the license to a provisional license shall be accompanied by a recommendation to the Secretary or his designee to suspend new admissions. A suspension may be ordered without the license being affected. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to adhere to rules and	C 015		

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

TITLE

(X6) DATE

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C 015	Continued From page 1 regulations related to admitting a resident (#4) to the facility after a notice of Suspension of Admissions was served. The findings are: Review of the facility's current license effective 01/01/25 through 12/31/25 revealed the facility was licensed for 6 ambulatory residents. Review of a letter issued by the Division of Health Service Regulation (DHSR) dated 10/07/24 revealed: -There was a biennial follow-up survey conducted by the construction Section at the facility on 09/17/24 at which time multiple deficiencies were identified. -The conditions of the home were found to be detrimental to the health, safety and welfare of the residents. -Admissions to the home were to be suspended immediately. Observations of the facility on 02/20/25 at 8:15am revealed the facility had a census of 6 residents. Review of Resident #4's current FL-2 dated 01/08/25 revealed: -Diagnoses included schizophrenia. -He was intermittently disoriented. Review of Resident #4's Resident Register revealed Resident #4 was admitted to the facility on 01/06/25. Interview with Resident #4 on 02/20/25 at 2:52pm revealed he was admitted to the facility about a month ago. Telephone interview with the Executive Director	C 015		

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C 015	Continued From page 2 on 02/21/25 at 4:43pm revealed: -He did not receive the Suspension of Admissions letter dated 10/07/24 from DHSR. -He admitted Resident #4 to the facility because the resident needed emergency placement. -He was aware of the deficiencies issued by the Construction Section of DHSR. -It was a simple mistake because he did not realize the facility had been issued a Suspension of Admissions.	C 015		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 6 sampled residents (#5) who did not respond to a fire drill. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 6	C 022		

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C 022	Continued From page 3 ambulatory residents. Review of the facility's fire drill logs for November 2024, December 2024 and January 2025 revealed: -The fire rehearsal/drill schedule was a form that was pre-populated with the description of actions taken. -Under the heading Fire Rehearsal, the actions taken included manually setting off the fire alarm. -All residents were instructed to exit their nearest exit. -Staff checked each room and common areas with the fire extinguisher in hand. -Residents were instructed to meet at the well in the yard. -Under the heading Emergency Evacuation Drills there was an explanation of evacuations drills that included activation of the alarm system to ensure fire protection and reliability with an orderly and disciplined evacuation designed to reinforce the message for all occupants to immediately move "out and away" from the facility to a predetermined meeting location. -On 11/13/24 at 1:00pm, the Executive Director and two named staff were present. -The total evacuation time was listed on the form, but the time was not documented. -The number of residents who participated in the evacuation drill was not documented. -On 12/17/24 at 3:00pm, the Executive Director and two named staff were present. -The total evacuation time was listed on the form, but the time was not documented. -The number of residents who participated in the evacuation drill was not documented. -On 01/13/25 at 5:00pm, the Executive Director and two named staff were present. -The total evacuation time was listed on the form, but the time was not documented.	C 022		

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C 022	Continued From page 4 -The number of residents who participated in the evacuation drill was not documented. Review of Resident #5's FL-2 dated 06/07/24 revealed: -Diagnoses included other intellectual disabilities and abnormal weight loss. -He was intermittently disoriented. -He was ambulatory. Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 04/07/20. Review of Resident #5's current care plan dated 03/17/22 revealed: -He required supervision from staff with eating and toileting. -He required limited assistance from staff with ambulation, bathing, dressing personal hygiene and transferring. Observation of a fire drill on 02/20/25 from 3:00pm to 3:05pm revealed: -The Supervisor-in-Charge (SIC) activated the fire alarm for the residents to evacuate the facility. -Resident #5 was in his bedroom with the door closed. -Resident #5's roommate exited the bedroom and closed the door behind him. -Resident #5 remained in his room while the fire alarm was going off. -Another resident approached Resident #5's bedroom calling Resident #5's name and announcing there was a fire drill and for Resident #5 to exit. -The resident opened Resident #5's bedroom door and told him to exit for the fire drill. -Resident #5 followed the resident down the hall and exited the facility with the rest of the	C 022		

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C 022	Continued From page 5 residents. Interview with a resident on 02/20/25 at 3:05pm revealed: -Resident #5 did not get up to leave during a fire drill. -He always notified Resident #5 when there was a fire drill because Resident #5 did not know what to do. -He would go get Resident #5 for every fire drill so Resident #5 would exit. Interview with a second resident on 02/20/25 at 3:50pm revealed: -He resided in the bedroom with Resident #5. -He would exit during a fire drill and go to the meeting place outside of the facility. -He did not tell Resident #5 to exit with him when there was a fire drill. -He never thought to tell Resident #5 to leave during a fire drill. -The SIC or another [named] resident would tell Resident #5 he had to leave every time there was a fire drill. -Resident #5 would just sit in his room and not exit if he was not told to leave. Interview with the SIC on 02/20/25 at 3:10pm revealed: -The last fire drill was conducted in January 2025 during a survey by the Construction Section for the Division of Health Services Regulation (DHSR). -Resident #5 did not exit on his own during the fire drill in January 2025. -Resident #5 usually did not exit on his own during a fire drill and would sit in his room with his fingers in his ears during fire drills. -He would not follow other residents out of the facility; another resident or staff would have to	C 022		

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C 022	Continued From page 6 tell him to exit the facility. -He could follow instructions, but he could not recognize or think to leave [exit] during a fire drill. Interview with the Administrator on 02/20/25 at 4:45pm revealed: -All the residents knew to evacuate during a fire drill. -Staff did not prompt or give instructions to leave the facility during a fire drill. -Other residents did not cue Resident #5 to evacuate. -Resident #5 was trained to leave the facility just like all other residents were trained to leave. -Fire drills were done once a month so the residents could be trained to leave the facility when they heard the alarm. -The fire alarm was sensitive to heat and smoke and would go off during cooking so maybe Resident #5 thought it was not a drill and did not leave. -He did not think Resident #5 would "just sit there" and not leave. Telephone interview with the Executive Director on 02/21/25 at 4:26pm revealed: -The residents knew they needed to "get out" during a fire drill. -Fire drills were conducted by the staff once a month. -Staff were instructed to conduct the fire drills at different times of the day. -Residents were taught to recognize the sound of the fire alarm and to exit with the sound. -Residents would see the state surveyors and staff not exiting so they did not exit either. -The residents changed from day to day, and he did not know how they would respond to a fire drill from day to day. -There may be a resident who might not feel well	C 022		

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C 022	Continued From page 7 and not want to evacuate or they could just refuse to evacuate. -He was aware there was an ongoing issue with Resident #5 not evacuating during fire drills. -Resident #5 was able to walk without assistance. -Resident #5 could exit on his own but it would vary depending on his mood. -He knew Resident #5 was not leaving and had to be prompted by the staff to evacuate the facility. -He understood for Resident #5's safety he should not be prompted to evacuate and would have to leave on his own; it could be the difference between life and death. -If there was an actual fire there may not be anyone to tell him to leave. Based on observations, record reviews, and interviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with Resident #5's primary care provider (PCP) on 02/21/25 at 11:31am was unsuccessful. The facility failed to ensure the building was equipped and maintained in accordance with the facility's licensed capacity to allow a resident (#5), who was known to have a cognitive impairment, and required prompting by facility staff to evacuate the facility independently in case of an emergency such as a fire. This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 7,	C 022		

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C 022	Continued From page 8 2025.	C 022		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 2 of 3 sampled residents (#2 and #3) who had orders for daily blood pressure checks. The findings are: 1. Review of Resident #2's current FL-2 dated 06/07/24 revealed: -Diagnoses included schizophrenia with paranoia, and anxiety disorder. -There was an order for blood pressure checks once daily. Review of Resident #2's medication administration records (MAR) for December 2024, January 2025 and February 2025 from 02/01/25 to 02/20/25 revealed: -There was no entry for once daily blood pressure checks or results. -There were no blood pressure checks or results documented.	C 249		

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C 249	Continued From page 9 Review of the facility's blood pressure log for January 2025 revealed -On 01/01/25, Resident #2's blood pressure was documented as 124 systolic and 88 diastolic. -There were no other blood pressures documented for Resident #2. Observation of Resident #2 on 02/20/25 at 1:31pm revealed: -The Supervisor-in-Charge (SIC) took Resident #2's blood pressure with a battery-operated blood pressure cuff. -Resident #2's blood pressure result was 119/78. Telephone interview with Resident #2's primary care provider (PCP) on 02/20/25 at 11:30am revealed: -She did not realize Resident #2 had an order for blood pressure checks once daily on his FL-2. -She did not see why she ordered blood pressure checks for Resident #2. -She had checked Resident #2's blood pressure on 02/11/25 and it was 111/ 90. -Resident #2 was not on any blood pressure medication and did not have hypertension. -She signed the FL-2 after a nurse in her office reviewed it for accuracy. -She only wrote orders for a daily blood pressure check if there was some kind of issue with the resident's blood pressure; she did not have an issue with Resident #2's blood pressure. Interview with Resident #2 on 02/20/25 at 1:31pm revealed: -The SIC took his blood pressure once a month. -He felt fine. -He did not have issues with his blood pressure. -He did not take blood pressure medication. -He did not know he had an order for daily blood	C 249		

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C 249	Continued From page 10 pressure checks. Interview with the SIC on 02/20/25 at 1:18pm revealed: -She took and documented all the residents' blood pressures once a month. -She had checked Resident #2's FL-2 when she placed it in his record just after it was signed. -She did not see the order for daily blood pressure checks on the FL-2. -Resident #2 had never had daily blood pressure checks. -She would have taken his blood pressure every day if she had known there was an order. -The order for the daily blood pressure check was not on the MAR. Refer to the telephone interview with the Administrator on 02/21/25 at 1:01pm. Refer to the telephone interview with the Executive Director on 02/21/25 at 3:46pm. 2. Review of Resident #3's current FL-2 dated 06/07/24 revealed: -Diagnoses included vascular dementia, chronic migraines, vision loss, history of stroke, and hypertension. -There was an order for blood pressure checks twice daily. Review of Resident #3's medication administration records (MAR) for December 2024, January 2025 and February 2025 from 02/01/25 to 02/20/25 revealed: -There was no entry for twice daily blood pressure checks or results. -There were no blood pressure checks or results documented.	C 249			

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C 249	Continued From page 11 Review of the facility's blood pressure log for January 2025 revealed -On 01/01/25, Resident #3's blood pressure was documented as 147 systolic and 87 diastolic. -There were no other blood pressures documented for Resident #3. Observation of Resident #3 on 02/20/25 at 5:45pm revealed: -The Supervisor-in-Charge (SIC) took Resident #3's blood pressure with a battery-operated blood pressure cuff. -Resident #3's blood pressure result was 142/92. Interview with Resident #3 on 02/20/25 at 5:05pm revealed: -The SIC took his blood pressure once a month. -He was not on any blood pressure medications, and he did not have high blood pressure. -His blood pressure was always good, and he always felt good. Interview with the SIC on 02/20/25 at 1:18pm and 5:40pm revealed: -She took and documented all the residents' blood pressures once a month. -She did not know Resident #3 had an order for blood pressure checks twice daily. -She thought she had reviewed his FL-2, but she did not see the order. -She did not realize the FL-2 she reviewed was not the current FL-2 dated 06/07/24 because it was not in his record until today, 02/20/25. -If she had know Resident #3 had an order for blood pressure checks twice daily she would have done them. Attempted telephone interview with Resident #3's primary care provider (PCP) on 02/21/25 at 11:31am was unsuccessful.	C 249		

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C 249	Continued From page 12 Refer to the telephone interview with the Administrator on 02/21/25 at 1:01pm. Refer to the telephone interview with the Executive Director on 02/21/25 at 3:46pm. Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: -The SIC was responsible for taking the residents' blood pressures and documenting them on the MAR or a log. -The SIC was responsible for following the MAR and the orders when she took the blood pressures. -The SIC told the Administrator she was taking the residents' blood pressures monthly and documenting them and taking some of them daily and documenting them. -He was responsible for ensuring the SIC was following orders and doing blood pressure checks as ordered. -He did monthly MAR audits and looked for the monthly and daily blood pressure results. -He was not sure how, but he had missed the blood pressure checks were not being done as ordered. Telephone interview with the Executive Director on 02/21/25 at 3:46pm revealed: -The Administrator was supposed to compare the FL-2 and MAR to ensure the orders for the blood pressure checks were on the MAR and completed when he did monthly MAR audits. -The results of the residents' blood pressure checks should have been documented on the MAR or a log sheet. -The SIC took blood pressures monthly for the residents and documented them on a log sheet. -He expected orders from the PCP for residents'	C 249			

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C 249	Continued From page 13 blood pressures that were ordered more frequently than once a month to be followed, completed, and documented by the facility staff.	C 249			
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) The facility shall assure that an appropriate licensed health professional participates in the on-site review and evaluation of the residents' health status, care plan, and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, TED hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples; (9) care of well-established colostomy or ileostomy. For the purpose of this Rule, "well-established colostomy or ileostomy" means having a healed surgical site without sutures or drainage; (10) care for pressure ulcers, up to and including	C 252			

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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 R 02/21/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON FAMILY 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)	(X5) COMPLETE DATE
C 252	Continued From page 14 a Stage II pressure ulcer, which is a superficial ulcer presenting as an abrasion, blister, or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube. For the purpose of this Rule, "well-established gastrostomy feeding tube" means having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established; (15) medication administration through subcutaneous injection in accordance with Rule .1004(q) except for anticoagulant medications; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include endotracheal suctioning. For the purpose of this Rule, "well-established tracheostomy" means the stoma is well-healed and the airway is patent; (20) administering and monitoring of tube feedings through a well-established gastrostomy feeding tube in accordance with Subparagraph (a)(14) of this Rule; (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises;	C 252		

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C 252	Continued From page 15 (26) any other prescribed physical or occupational therapy; (27) transferring semi-ambulatory or non-ambulatory residents; or (28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that Act in 21 NCAC 36. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed quarterly for 1 of 1 sampled residents (#1) with task of fingerstick blood sugars (FSBS). The findings are: Review of Resident #1's current FL-2 dated 06/07/24 revealed: -Diagnoses included anxiety, schizophrenia, and type 2 diabetes. -There was an order for FSBS checks once weekly. Review of Resident #1's Resident Register revealed he was admitted to the facility on 08/21/20. Review of Resident #1's FSBS logs for January 2025 and February 2025 from 02/01/25 to 02/14/25 revealed: -Resident #1's FSBS results were documented twice daily for January 2025. -Resident #1's FSBS results were documented	C 252		

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C 252	Continued From page 16 twice daily from 02/01/25 to 02/14/25. Review of Resident #1's medication administration records (MAR) for January 2025 and February 2025 from 02/01/25 to 02/14/25 revealed: -There was an entry to check FSBS and record results twice daily scheduled at 8:00am and 8:00pm. - Resident #1's FSBS were documented as checked twice daily. -There was a second entry for FSBS twice weekly and record. -There was nothing documented on the entry. Review of Resident #1's record revealed: -There was a LHPS evaluation dated 04/11/24 with no LHPS tasks checked for collecting and testing FSBS. -There were no other LHPS evaluations in Resident #1's record. Review of Resident #1's LHPS evaluation dated 01/15/25 revealed: -The Administrator provided the LHPS for Resident #1's. -The LHPS evaluation had no LHPS tasks checked for collecting and testing FSBS. -There were no other LHPS evaluations in Resident #1's record and no additional ones were provided. Interview with Resident #1 on 02/20/25 at 3:40pm revealed he did his own FSBS checks twice a day since he was admitted to the facility. Telephone interview with the Resident #1's primary care provider (PCP) on 02/20/25 at 11:20am revealed: -She provided the facility staff at the main office	C 252		

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C 252	Continued From page 17 located in a sister facility with a copy of Resident #1's LHPS evaluation for the current quarter. -She had completed a current LHPS evaluation for Resident #1 in January and could fax a copy to the surveyor. -Resident #1 had LHPS tasks for administration of medication through injection but no other task. -She did not realize there was an order for FSBS checks twice weekly on his FL-2. Interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 9:10am revealed Resident #1 did FSBS checks twice daily himself. Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: -Resident #1 did FSBS checks; he had seen the results the log. -Resident #1 had an order for the FSBS checks if they were being done. -He thought the FSBS checks were on Resident #1's LHPS evaluation, but he could not say. -The PCP completed the LHPS evaluations quarterly. Telephone interview with the Executive Director on 02/21/25 at 3:26pm revealed: -The PCP completed the residents' LHPS evaluations. -The Assistant Administrator was responsible for ensuring they were completed quarterly. -The facility did not check to see if the LHPS task were complete on the evaluation or if they were done correctly because the facility staff were not physicians.	C 252		
C 265	10A NCAC 13G .0904(c)(2) Nutrition And Food Service	C 265		

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NAME OF PROVIDER OR SUPPLIER JEFFERSON FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 495 STALEY BOSWELL ROAD YANCEYVILLE, NC 27379		
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C 265	Continued From page 18 10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure a was menu available in the kitchen for the daily meals and was used for guidance for staff when preparing resident meals. The findings are: Observation of the kitchen on 02/20/25 at 8:55am revealed there was no weekly or daily menu posted in the kitchen. Observation of the lunch meal on 02/20/25 from 11:58am to 12:26pm revealed the residents were served baked tilapia fish, green beans and corn blend, creamed potatoes with cheese, a biscuit, fruit cup, fruit punch from a powdered drink mix, and water. Observation of the dinner meal on 02/20/25 from 5:10pm to 5:35pm revealed the residents were served beef and chicken stew, saltine crackers, a biscuit, fruit cup, fruit punch made from a powdered drink mix, milk and water.	C 265		

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C 265	Continued From page 19 Interview with two residents on 02/20/25 at 12:01pm revealed: -The food was good. -They liked what was prepared. -They did not know about the menu. -The Supervisor-in-Charge (SIC) told them what the meal was if they asked, and she told them when she served it to them. -They got a variety of food. Interview with the SIC on 02/20/25 at 8:55am revealed: -She did not have a menu to follow when she prepared meals for the residents. -She decided what to prepare based on what was available to cook and what the residents liked. -She made sure there was meat, vegetables, dairy and a starch at every meal. -She served fruit at snack times and with some of the meals. -The Administrator had never said anything to her about not following a menu. Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: -The facility had a cycle menu and the SIC was expected to follow it when she prepared meals. -He had not monitored meals at the facility in a long time. -He visited the facility at mealtimes but did not review the menu because he thought the SIC was following the menu like she was supposed to. Telephone interview with the Executive on 02/21/25 at 3:46pm revealed: -The facility had a cycle menu. -There was a manual at the facility with menus. -The SIC was trained to post the menu each week in the kitchen and to follow it so the residents knew what they were going to be	C 265		

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C 265	Continued From page 20 served at meals. -He expected the SIC to follow the menu. -The Administrator should monitor the meals at the facility to make sure the menu was followed.	C 265		
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure matching therapeutic menus for food service staff for guidance when preparing meals for 1 of 1 sampled residents (#3) with a physician order for a low sodium diet. The findings are: Review of Resident #3's current FL-2 dated 09/13/23 revealed: -Diagnoses included vascular dementia, chronic migraines, vision loss, history of stroke, hypertension and schizophrenia. -There was a diet order for a low sodium diet. Observation of the kitchen on 02/20/25 at 8:55am revealed there were no menus and no therapeutic diet menus for the staff to use for guidance when	C 270		

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C 270	Continued From page 21 preparing meals. Observation of the lunch meal on 02/20/25 from 11:58am to 12:26pm revealed: -The residents were served baked tilapia fish, green beans and corn blend, creamed potatoes with cheese, a biscuit, fruit cup, fruit punch from a powdered drink mix, and water. -Resident #3 ate 100 percent of his dinner meal. Observation of the dinner meal on 02/20/25 from 5:10pm to 5:35pm revealed: -The residents were served beef and chicken stew, saltine crackers, a biscuit, fruit cup, fruit punch made from a powdered drink mix, milk and water. -Resident #3 ate 100 percent of his dinner meal. Interview with Resident #3 on 02/20/25 at 5:05pm revealed: -He was not ordered any special or therapeutic diets by his primary care provider (PCP). -He did not know what a low sodium diet was. Interviews with the Supervisor-in-Charge (SIC) on 02/20/25 at 8:55am and 4:55pm revealed: -None of the residents had orders for therapeutic diets. -She did not follow any menus; she made up the meals for the day based on what she had available and what the residents liked to eat. -She would not be able to follow the therapeutic diet menu because she made her own daily menu. -She did not know Resident #3 was ordered a low sodium diet. -She had a manual with diets in it in her living quarters, but she did not use it and she did not know if it had a low sodium diet.	C 270		

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C 270	Continued From page 22 Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: -He could not say if Resident #3 was ordered a low sodium diet because he had so many residents to keep track of. -The facility had a therapeutic diet menu and the SIC should have followed it. -The SIC should know the residents' diets because they were on the diet list and on the FL-2s. -He had not monitored meals at the facility in a long time. -He visited the facility at mealtimes but did not review the diets or the menu. Telephone interview with the Executive Director on 02/21/25 at 3:46pm revealed: -There was a manual at the facility with menus. -The facility had a cycle menu including therapeutic diets; he was sure there was a low sodium diet in the manual. -The SIC was supposed to look at the therapeutic menu and follow it for meals. -He expected the SIC to follow the therapeutic diet menu. -The therapeutic diet manual should have been kept in the kitchen for the SIC to use. -The SIC needed more training; she knew to follow the therapeutic diet menus. -The Assistant Administrator should have monitored the meals at the facility to make sure the therapeutic diet menu was followed. Attempted telephone interview with Resident #3's PCP on 02/21/25 at 11:31am was unsuccessful.	C 270		
C 283	10A NCAC 13G .0904 (e)(3) Nutrition And Food Service	C 283		

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C 283	Continued From page 23 10A NCAC 13G .0904 Nutrition And Food Service Therapeutic Diets in Family Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure an accurate therapeutic diet list for 2 of 3 (#1, #2) sampled residents was accurate. The findings are: Observation of the kitchen on 02/20/25 at 8:55am revealed: -There was a diet list posted on a bulletin board in the kitchen next to the refrigerator. -There were six residents on the diet list. -There was a resident who no longer resided at the facility on the list. -There was a resident who currently resided at the facility who was not on the diet list. -There were five residents who were ordered a regular diet and one resident with an order for a no concentrated sweets (NCS) diet. -The diet list was not dated. 1. Review of Resident #2's current FL-2 dated 06/07/24 revealed: -Diagnoses included schizophrenia with paranoia, and anxiety disorder. -There was an order for a regular diet. Observation of the diet list posted in the kitchen	C 283			

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C 283	Continued From page 24 on 02/20/25 at 8:55am revealed a NCS therapeutic diet was listed for Resident #2. Interview with Resident #2 on 02/20/25 at 1:31pm revealed: -He was not on a physician's ordered therapeutic diet. -He was not diabetic, so he did not know why he was on the diet list for a NCS diet. Attempted telephone interview with Resident #2's primary care provider (PCP) on 02/21/25 was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 8:55am. Refer to the telephone interview with the Assistant Administrator on 02/21/25 at 1:01pm. Refer to the telephone interview with the Administrator on 02/21/25 at 3:46pm. 2. Review of Resident #3's current FL-2 dated 06/07/24 revealed: -Diagnoses included vascular dementia, chronic migraines, history of stroke, hypertension, schizophrenia and vision loss. -There was an order for a low sodium diet. Observation of the diet list posted in the kitchen on 02/20/25 at 8:55am revealed Resident #3 was listed as having a low sodium diet. Interview with Resident #3 on 02/20/25 at 5:05pm revealed he was not on any special diets; he was not on a low sodium diet. Interview with the Supervisor-in-Charge (SIC) on	C 283		

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C 283	Continued From page 25 02/20/25 at 4:55pm revealed: -She did not know Resident #3 was on a low sodium diet. -No one told her he was on a low sodium diet, and he was on the diet list as a regular diet. Attempted telephone interview with Resident #3's primary care provider (PCP) on 02/21/25 was unsuccessful. Refer to the interview with the SIC on 02/20/25 at 8:55am. Refer to the telephone interview with the Administrator on 02/21/25 at 1:01pm. Refer to the telephone interview with the Executive Director on 02/21/25 at 3:46pm. Interview with the SIC on 02/20/25 at 8:55am revealed: -None of the residents had physicians' orders for therapeutic diets. -She did not follow the diet list because it was old. Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: -He could not say what therapeutic diets the residents were ordered because he had so many residents to keep track of. -The facility had a therapeutic diet list and the SIC should have followed it. -The SIC should know the residents' diet because they were on the diet list and on the FL-2s. -The diet list was updated as new residents were admitted or when residents were discharged, when new FL-2s were signed or when there was a diet order change. -He or the Administrator updated the diet list. -He did not know the last time the diet list was	C 283		

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C 283	Continued From page 26 updated. -He was responsible for posting the updated diet list as soon as there was a change. -He visited the facility at mealtimes but did not review the diets. Telephone interview with the Executive Director on 02/21/25 at 3:46pm revealed: -The Administrator was responsible for updating the diet list. -The diet list was updated as soon as a new resident was admitted, new FL-2s were signed or when there was a new diet order for a resident. -The SIC was supposed to use the diet list to know which residents had diets and what therapeutic diets to prepare. -He expected the SIC to follow the diet list. -The SIC also could reference the FL-2s and any order changes from the resident records. -The Administrator should have monitored the meals at the facility to make sure the therapeutic diet list was updated.	C 283		
C 317	10A NCAC 13G .1002 (c) Medication Orders 10A NCAC 13G .1002 Medication Orders c) The medication orders shall be complete and include the following: (1) medication name; (2) strength of medication; (3) dosage of medication to be administered; (4) route of administration; (5) specific directions of use, including frequency of administration; and (6) if ordered on an as needed basis, a stated indication for use.	C 317		

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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 R 02/21/2025
NAME OF PROVIDER OR SUPPLIER JEFFERSON FAMILY 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)	(X5) COMPLETE DATE
C 317	Continued From page 27 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to obtain clarification for an order for the frequency of finger stick blood sugar (FSBS) checks for 1 of 3 residents (#1). The findings are: Review of Resident #1's FL-2 dated 06/07/24 revealed: -Diagnoses included anxiety, schizophrenia, depression, type 2 diabetes, tachycardia and chronic obstructive pulmonary disease (COPD). -There was an order for FSBS checks twice weekly. Review of Resident #1's FSBS log for February 2025 revealed Resident #1 had documented FSBS checks twice daily. Review of Resident #1's December 2024 medication administration records (MARs) revealed: -There was an entry to check FSBS and record results twice daily scheduled at 8:00am and 8:00pm. - Resident #1's FSBS were documented as checked twice daily. -There was a second entry for FSBS twice weekly and record. -There was nothing documented on the entry. Review of Resident #1's January 2025 MARs revealed: -There was an entry to check FSBS and record results twice daily scheduled at 8:00am and 8:00pm. - Resident #1's FSBS were documented as	C 317		

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C 317	Continued From page 28 checked twice daily. -There was a second entry for FSBS twice weekly and record. -There was nothing documented on the entry. Review of Resident #1's February 2025 MAR from 02/01/25 to 02/20/25 revealed: -There was an entry to check FSBS and record results twice daily scheduled at 8:00am and 8:00pm. - Resident #1's FSBS were documented as checked twice daily from 02/01/25 to 02/20/25. -There was a second entry for FSBS twice weekly and record. -There was nothing documented on the entry from 02/01/25 to 02/20/25. Telephone interview with Resident #1's primary care provider (PCP) on 02/20/25 at 11:20am revealed: -Resident #1 did not have an order for FSBS checks. -She did not realize there was an order for FSBS checks twice weekly on his FL-2. -She would not have ordered FSBS checks twice daily or twice weekly for Resident #1 because he did not require insulin injections to manage his diabetes. Interview with Resident #1 on 02/20/25 at 3:40pm revealed: -He did his own FSBS checks twice a day since he was admitted to the facility. -He had not been told to do his FSBS less than twice daily. -It would be nice not to have to do FSBS checks twice daily because he got tired of sticking his fingers. Interview with the Supervisor-in-Charge (SIC) on	C 317		

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C 317	Continued From page 29 02/20/25 at 1:18pm revealed: -She knew there were two different entries on the MAR for Resident #1's FSBS check; she knew one entry was for twice a day and one entry was for twice a week. -She knew the order for FSBS checks were on Resident #1's FL-2 for twice a week but she went by the MAR. -The previous PCP had changed Resident #1's FSBS checks to twice a day; she did not know if the change was before or after the current FL-2 was signed. -Resident #1 told her he had FSBS checks twice daily. -She followed the order on the MAR and what Resident #1 told her. -She had not told the Administrator or anyone else about the two different entries on the MAR. -She did not question it; she made sure Resident #1 did his FSBS checks twice daily. Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: -Resident #1 did FSBS checks twice daily; he had seen the results documented on the FSBS log. -The SIC should follow the MAR when Resident #1 did his FSBS checks. -If Resident #1 did not have an order for FSBS checks twice daily then they should not have been done twice daily. -The FL-2 should mimic the MAR; the MAR was sent to the pharmacy. -He did not know how there were two different orders for FSBS checks on Resident #1's MAR. -The pharmacy should have removed the discontinued orders from the MAR and only entered the new order. -The SIC could call the pharmacy and tell them to remove the discontinued order from the MAR or ask which order was correct.	C 317		

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C 317	Continued From page 30 -He conducted monthly audits of the MARs, but he must have missed the two FSBS orders. -He did not know which order was current. -Resident #1 should not be doing FSBS checks twice daily if he did not have an order for them. Telephone interview with the Executive Director on 02/21/25 at 3:26pm revealed: -There should have been an order with the correct frequency for Resident #1's FSBS checks. -Resident #1's FL-2 should have been reviewed by the Assistant Administrator. -The PCP should have reviewed the MAR to see if the orders were correct. -The Administrator should have compared the FL-2 after the PCP signed it to the MAR to ensure that the correct order was being followed. -The Administrator should reach out to the PCP or the pharmacy if the orders were not correct on the MAR. -Resident #1 should not have been doing FSBS checks twice daily if there was not an order.	C 317		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION	C 330		

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C 330	Continued From page 31 Based on observations, interviews, and record reviews, the facility failed to ensure medication was administered as ordered for 1 of 3 sampled residents (#1) related to an antipsychotic medication and an antibiotic. The findings are: Review of Resident #1's FL-2 dated 06/07/24 revealed diagnoses included anxiety, schizophrenia, depression, type 2 diabetes, tachycardia and chronic obstructive pulmonary disease (COPD). a. Review of Resident #1's FL-2 dated 06/07/24 revealed there was an order for paliperidone (used to treat schizophrenia) 819mg inject 2.63mL intramuscular every three months. Review of Resident #1's mental health provider (MHP) report of health services dated 10/01/24 revealed: -Resident #1 was administered an injection in his right upper arm. -There was no documentation of the medication name or amount of medication administered, and the frequency was documented as a "Q" [every], a drawn blank line with nothing documented on it, and "month". -There was documentation the resident tolerated the injection well and had no adverse reaction. -The MHP initialed the report. Review of Resident #1's November 2024 medication administration record (MAR) revealed: -There was an entry for paliperidone 819mg/2.63 inject 819mg intramuscularly once every three months scheduled at 8:00am. - "Nurse Only" was handwritten across the dates	C 330		

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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 R 02/21/2025
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C 330	Continued From page 32 on the entry. -There was no documentation paliperidone was administered on any dates from 11/01/24 to 11/30/24. Review of Resident #1's December 2024 MARs revealed: -There was an entry for paliperidone 819mg/2.63 inject 819mg intramuscularly once every three months scheduled at 8:00am. - "Nurse Only" was handwritten across the dates on the entry. -There was no documentation paliperidone was administered in December 2024. Review of Resident #1's January 2025 MAR revealed: -There was an entry for paliperidone 819mg/2.63 inject 819mg intramuscularly once every three months scheduled at 8:00am. - "Nurse Only" was handwritten across the dates on the entry. -There was no documentation paliperidone was administered on any dates from 01/01/25 to 01/31/25. Review of Resident #1's February 2025 MAR from 02/01/25 to 02/20/25 revealed: -There was an entry for paliperidone 819mg/2.63mL inject 819mg intramuscularly once every three months. - "Nurse Only" was handwritten across the dates on the entry. -There was no documentation paliperidone was administered from 02/01/25 to 02/20/25. Observation of Resident #1's medication on hand on 02/20/25 at 12:47pm revealed: -There was a box with a single preloaded injectable pen of paliperidone 819mg/2.63mL	C 330			

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C 330	Continued From page 33 dispensed on 08/22/24. -The box was sealed and unopened. -The directions on the box read administer every three months. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/20/25 at 2:00pm revealed: -Resident #1 had an order for paliperidone 819mg/2.63mL inject once every twelve weeks or every three months; the order needed to be renewed but had not been discontinued either. -Paliperidone 819mg/2.63mL was dispensed once every three months, and one pen was dispensed in each box. -Resident #1 had one paliperidone pen dispensed on 03/07/24, 05/31/24 and 08/28/24; there were no other dispense dates. -He did not know the dates the medication was actually administered but it appeared the resident was behind on the injections because there had not been a pen dispensed since August 2024. -Paliperidone was a long-acting antipsychotic medication used to treat multiple psychiatric diagnoses. Interview with Resident #1 on 02/20/25 at 3:40pm revealed: -The last time he received a paliperidone injection was last year sometime in 2024; he did not recall which month. -He was administered his shot by a nurse that came to the facility every three months. Interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 1:32pm revealed: -She could not administer Resident #1 his paliperidone; the MHP administered the injection once every three months. -She would send the box with the paliperidone	C 330		

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C 330	Continued From page 34 pen with the resident and the MHP would administer the injection. -The paliperidone pen was cycle-filled from the pharmacy one box at a time. -She did not realize Resident #1's paliperidone pen on the medication cart was dispensed in August 2024. -The pharmacy usually dispensed it "one week after the other" so maybe that was why there was an extra box of paliperidone for Resident #1. -The MHP documented the injection on Resident #1's MARs. Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: - Resident #1's MHP administered the paliperidone injection. -The documentation of the injection [administration] should be on the MHP health services report. -The MHP also documented administration of the paliperidone on the MAR. -He did monthly MAR audits to ensure the injection was done; he looked for the administration documentation when he did the audits. -He did not recall that there was documentation if Resident #1 was administered the injection in January 2025. -He did see the paliperidone pen on the medication cart during the January 2025 audit. -The dispense date on the box for the paliperidone pen should have alerted him there was an issue. -He should have contacted the MHP to see if the resident was administered his injection. -He should have looked into why there was an extra paliperidone pen, if Resident #1 was behind or had missed an injection, and why there was no documentation of administration.	C 330		

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C 330	Continued From page 35 -Now there was no way to know if Resident #1 had been administered his paliperidone as ordered. Telephone interview with the Executive Director on 02/21/25 at 4:06pm revealed: -The SIC was responsible for ensuring Resident #1's paliperidone was administered and documented after administration, even if the MHP administered the injection. -If there was a missed month or an extra paliperidone pen, the SIC should have called the Administrator and let him know there was an extra dose. -The MAR represented the order and the documentation on the MAR represented the administration of the medication. -He expected the paliperidone to be administered as ordered, even when the MHP administered it. Attempted telephone interview with Resident #1's MHP on 02/21/25 at 11:31am was unsuccessful. Based on MAR reviews, interviews, and observations of medication on hand, it could not be determined if Resident #1's paliperidone was administered. b. Review of Resident #1's after-visit report from the local hospital dated 12/31/24 revealed: -Resident #1 was seen in the Emergency Department (ED) due to swelling in his lower left extremity and foot. -Resident #1 was diagnosed with swelling, mass and lump in the lower left limb. Review of Resident #1's physicians order dated 12/31/24 revealed there was an order for cefalexin (used to treat infections) 500mg once every eight hours (three times daily) for seven	C 330			

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C 330	Continued From page 36 days. Review of Resident #1's medication administration records (MAR) for December 2024 revealed: -There was no entry for cefalexin 500mg once every eight hours for seven days. -There was no documentation Resident #1 was administered cefalexin 500mg every eight hours for seven days. Review of a physician's order for Resident #1 provided by the facility's contracted pharmacy on 02/21/25 revealed: -The order was for Resident #1 was from a local hospital dated 12/31/24. -The order was for cefalexin 500mg once every eight hours for seven days. -The fax information printed at the top of the order indicated it was faxed from the facility on 01/21/25 at 6:48pm; there was no indication as to where the order was faxed. -The fax information printed at the bottom of the order indicated it was faxed from a sister facility on 01/22/25 at 6:08am; there was no indication as to where the order was faxed. Review of Resident #1's January 2025 MAR revealed: -There was no entry for cefalexin 500mg once every eight hours for seven days. -There was no documentation Resident #1 was administered cefalexin 500mg every eight hours for seven days. Review of Resident #1's February 2025 MAR from 02/01/25 to 02/20/25 revealed: -There was no entry for cefalexin 500mg once every eight hours for seven days. -There was no documentation Resident #1 was	C 330			

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C 330	Continued From page 37 administered cefalexin 500mg every eight hours for seven days. Observation of Resident #1's medication on hand on 02/20/25 at 12:47pm revealed there was no cefalexin 500mg available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/20/25 at 2:00pm revealed: -There was an order for Resident #1 for cefalexin faxed to the pharmacy on 01/22/25. -The order was for cefalexin 500mg every eight hours for seven days. -Twenty-one tablets of cefalexin 500mg were dispensed on 01/22/25. -Cefalexin was an antibiotic used to treat infections. Interview with Resident #1 on 02/20/25 at 3:40pm revealed: -His foot started to swell sometime around the end of December 2024. -He went to the ED at the local hospital. -His foot got better and was not swollen after about a week. -He did not know if he was ordered an antibiotic for his foot. -He was not told what was wrong with his foot; he knew it was not broken. -No one told him if his foot was infected. -He did not know if he took an antibiotic after he went to the ED. -He did not look at his medications; he just took them when they were handed to him. Interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 4:55pm revealed: -Resident #1 had an order for cefalexin in January 2025.	C 330		

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C 330	Continued From page 38 -She faxed medication orders to the facility's main office and the Administrator or the Executive Director sent the order to the pharmacy. -She did not recall if she faxed the order to the facility's main office or if the physician faxed the order to the pharmacy. -She did not recall there being a delay in the dispensing of Resident #1's cefalexin. -The cefalexin was delivered by the pharmacy and she administered it to Resident #1 for seven days. -She followed the directions [orders] on the label on the package. -She called the pharmacy and requested a MAR with the cefalexin on it, but the pharmacy told her they could not send a MAR with just one medication on it in the middle of the month. -She did not write the entry on the MAR for the cefalexin because she did not write on the MAR. -She knew Resident #1 was administered his cefalexin correctly because she was the one who administered it to him. Telephone interview with the Administrator on 02/21/25 at 1:01pm revealed: -He thought Resident #1 had been to the hospital, but he was not sure why or when he went. -He was responsible for making sure any new medication orders were sent to the pharmacy via fax. -The SIC was responsible for faxing the orders to the main office and then he was responsible for faxing them to the pharmacy. -He was not aware there was a delay in Resident #1's cefalexin order being sent to the pharmacy. -The order for the cefalexin should have been sent to the pharmacy the day it was written or first thing the next morning if the resident came back from the ED late at night. -There should never have been a 22-day delay in	C 330		

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C 330	Continued From page 39 the order being sent and filled. -He did not reach out to Resident #1's primary care provider (PCP) to see if the cefalexin could or should still be administered after a 22-day delay in receiving the medication. -There should not have been that long of a delay for any medication orders to be sent to the pharmacy. Telephone interview with the Executive Director on 02/21/25 at 4:06pm revealed: -The SIC was responsible for reviewing the after-visit report from the ED. -The SIC would fax the after-visit report to him and he would forward it to the PCP. -The SIC would fax medication orders that were with the after-visit report to the pharmacy. -If the SIC was not able to send the medication orders to the pharmacy, then she would fax them to the main office and then he would fax them to the pharmacy. -There had been some issues with hospital discharge and after-visit reports not being found [misplaced] at the facility or the main office so they were now being downloaded onto a drive at the main office. -He did not know why there was a delay in the medication order for Resident #1's cefalexin being faxed to him. -He had not noticed the date of 12/31/24 on the order when he received it in January 2025. -He received the medication order via facsimile on 01/21/25 and he faxed it to the pharmacy first thing in the morning the next day, 01/22/25. -He did not know if the PCP was contacted about the order for the cefalexin to see if it should have been administered after not administering it for over 20 days. -If he had caught the date on the order he would have reached out to the PCP about the cefalexin.	C 330		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 330	Continued From page 40 -The SIC should have documented the administration of the cefalexin. -If the order was not on the MAR the SIC could have written it in or called the pharmacy for a MAR sheet with the order. -No medication should be administered without a MAR. Attempted telephone interview with Resident #1's PCP on 02/21/25 at 11:31am was unsuccessful. The facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#1) including an antipsychotic medication administered by intramuscular injection that was ordered every three months and had not been administered for four months; and an antibiotic that was ordered for seven days and the facility did not send the order to the pharmacy for 22 days which delayed the administration of the antibiotic to the resident. This failure was detrimental to the health and well-being of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/20/25 for this violation. THE CORRECTION DATE FOR TH TYPE B VIOLATION SHALL NOT EXCEED APRIL 7, 2025.	C 330			
C 415	10A NCAC 13G .1201 (a) Resident Records 10A NCAC 13G .1201 Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's	C 415			

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C 415	Continued From page 41 record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.	C 415		

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C 415	Continued From page 42 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure information was maintained in each resident's record in the facility and available for review for 4 of 5 sampled residents (#1, #2, #3, and #5) including current care plans (#1, #2, #3 and #5), physicians' orders (#1, #2, #3 and #5), and current FL-2s (#3). The findings are: 1. Review of Resident #1's FL-2 dated 06/07/24 revealed diagnoses included anxiety, schizophrenia, depression, type 2 diabetes, tachycardia and chronic obstructive pulmonary disease (COPD). Review of Resident #1's record revealed the most current care plan was dated 03/17/22. Review of Resident #1's record revealed there were no physicians' orders from May 2024 to February 2025. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/20/25 at 11:20am. Refer to the interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 1:18pm. Refer to the telephone interview with Administrator on 02/20/25 at 11:45am. Refer to the telephone interview with the Executive Director on 02/21/25 at 3:26pm.	C 415		

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C 415	Continued From page 43 2. Review of Resident #2's FL-2 dated 06/07/24 revealed diagnoses included schizophrenia with paranoia, and anxiety disorder. Review of Resident #2's record revealed the most recent care plan was dated 06/15/22. Review of Resident #2's record revealed there was no documentation of physician orders from May 2024 to February 2025. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/20/25 at 11:20am. Refer to the interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 1:18pm. Refer to the telephone interview with Administrator on 02/20/25 at 11:45am. Refer to the telephone interview with the Executive Director on 02/21/25 at 3:26pm. 3. Review of Resident #3's most recent FL-2 dated 09/13/23 revealed diagnoses included vascular dementia, chronic migraines, vision loss, history of stroke, hypertension and schizophrenia. Review of Resident #3's record revealed the most recent care plan was dated 01/06/22. Review of Resident #3's record revealed there was no documentation of physician orders from May 2024 to February 2025. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/20/25 at 11:20am.	C 415		

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C 415	Continued From page 44 Refer to the interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 1:18pm. Refer to the telephone interview with Administrator on 02/20/25 at 11:45am. Refer to the telephone interview with the Executive Director on 02/21/25 at 3:26pm. Telephone interview with the facility's primary care provider (PCP) on 02/20/25 at 11:20am revealed: -She had seen Resident #3 and had completed a current FL-2 for him. -She did not have her records with her so she could not remember the date. -She gave copies of the FL-2 to the facility staff for the residents' records. Telephone interview with the Administrator on 02/20/25 at 11:45am revealed: -He had audited Resident #3's record in January 2025 and his current FL-2 was in the record. -He did not know why Resident #3's current FL-2 was not in his record. -He would have to obtain a copy of the FL-2 from Resident #3's PCP. Refer to the telephone interview with the facility's PCP on 02/20/25 at 11:20am. Refer to the interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 1:18pm. Refer to the telephone interview with Administrator on 02/20/25 at 11:45am. Refer to the telephone interview with the	C 415			

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C 415	Continued From page 45 Executive Director on 02/21/25 at 3:26pm. 4. Review of Resident #5's current FL-2 dated 06/07/24 revealed diagnoses included other intellectual disabilities and abnormal weight loss. Review of Resident #5's record revealed the most recent care plan was dated 03/17/22. Review of Resident #5's record revealed there was no documentation of physician orders from May 2024 to February 2025. Refer to the telephone interview with the facility's primary care provider (PCP) on 02/20/25 at 11:20am. Refer to the interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 1:18pm. Refer to the telephone interview with Administrator on 02/20/25 at 11:45am. Refer to the telephone interview with the Executive Director on 02/21/25 at 3:26pm. _____ Telephone interview with the facility's primary care provider (PCP) on 02/20/25 at 11:20am revealed: -She was at the facility on 02/11/25 and saw the residents. -She signed care plans when she signed new FL-2s. -She gave the facility staff copies of the care plans. -The copies of the PCP orders were given to one of the Administrators at the facility's main office located in a sister facility. -The residents visited her at her office as needed or quarterly.	C 415		

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C 415	Continued From page 46 -She also provided monthly mental health services to the residents at her office. -She had signed all the documents and left copies with the facility. Interview with the Supervisor-in-Charge (SIC) on 02/20/25 at 1:18pm revealed: -Sometimes the Assistant Administrator brought documents for the resident records, and she would put them in the records. -Sometimes the Assistant Administrator put documents in the resident records. -She kept the resident records organized. -She did not reference the PCP orders or the care plans; she only referenced the FL-2. Telephone interview with the Administrator on 02/20/25 at 11:45am revealed: -After the PCP signed the care plans, LHPS, PCP orders and FL-2s she left copies or sometimes emailed them to the main office located in a sister facility. -The Assistant Administrator was responsible for getting the documents from the main office and bringing them to the facility to file in the resident records. -He could not say why the resident records were missing any care plans, PCP orders or FL-2s. -He thought the residents' care plans were up to date and current. -The care plans may have been removed from the resident records to make copies; he could not think of any other reason why they were not in the resident records. -The PCP orders should have been in the resident records within a week of the PCP's visit with the resident. -He was responsible for placing the PCP orders in the residents' records; he did not know why they were not in the records.	C 415		

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C 415	Continued From page 47 -He used a check list when he conducted resident record audits monthly. -The list included looking at current FL-2s, care plans, and PCP orders . -The last time he had audited the resident records was sometime in January 2025; everything was in the records at that time. -He did not document the record audits. -If there were copies of the care plans, PCP health services records, or other documents at the main office he would bring them to the facility today, 02/20/25. Telephone interview with the Executive Director 02/21/25 at 3:26pm revealed: -The Administrator and himself were responsible for the resident records and ensuring the care plans, physicians' orders, and FL-2s were completed and in the residents' records. -The Administrator was responsible for conducting monthly record audits. -The Administrator used a checklist when he did the record audits. -He did not review the residents' record audits after the Administrator did them. -The Assistant Administrator would let him know if something was missing from a resident's record. -Biannually he would sit with the SIC and the Assistant Administrator and ask about the residents' records, but he did not look at the records. -Lately the facility had a challenge getting documents from the PCP after her visits. -The PCP would complete her documentation of visits, sign FL-2, care plans and orders after she visited the residents and would send them to the main office in an email. -The Assistant Administrator was responsible for printing the documents and then taking them to the facility to place them in the residents' records.	C 415		

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C 415	Continued From page 48 -Documents from the PCP should be in the residents' records no later than one week after the PCP signed them. -He did not know why everything was not in the records.	C 415			