

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	1. Immediate Suspension of Admissions: a. The facility has immediately suspended all admissions effective [2/25/2025], pending further clarification and resolution with DHSR. b. No further residents will be admitted until the facility is in full compliance with DHSR regulations, and the suspension is lifted.		2/25/2025
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	2. Staff Training: a. All facility staff, including the Executive Director, management, and admissions personnel, will undergo mandatory training on the importance of reviewing all official correspondence from DHSR and understanding the regulations related to suspensions of admissions. b. The training will include a review of the licensing requirements and procedures to follow when admissions are suspended. c. The training will be completed by [2/21/2025]. Communication Protocol: d. The Executive Director will implement a new protocol for reviewing and tracking all official communications from DHSR. This includes setting up an internal log to track and confirm the receipt of all letters, notices, and regulatory communications from DHSR. e. A designated staff member will be responsible for immediately notifying the Executive Director and senior staff of any suspensions, conditions, or regulatory changes from DHSR. f. The new communication protocol will be implemented by [2/21/2025]. 3. Review of Admissions Policy: a. The facility's admissions policy will be reviewed and revised to ensure it is clear, comprehensive, and aligned with DHSR guidelines. The revised policy will include procedures for verifying the status of admissions at the time of each new admission to ensure compliance with any suspension orders. b. The policy will be reviewed by [insert date] and any changes will be implemented immediately. 4. Follow-up to DHSR: a. The facility will submit a written corrective action plan to DHSR by [2/25/2025], outlining the steps the facility has taken to correct the deficiencies and prevent future violations. b. The facility will request a follow-up inspection from DHSR to verify compliance with the suspension of admissions order and confirm that all deficiencies have been addressed. 5. Resident #4's Care and Placement: a. Resident #4's admission will be reviewed by the facility's clinical team to ensure that his care needs are appropriately met in accordance with his FL-2 (dated 01/08/25). b. The facility will ensure that Resident #4 receives appropriate care in a safe and compliant environment, considering his diagnoses and disorientation issues. c. The facility will coordinate with local health authorities and case managers to ensure that Resident #4's needs are met during this transitional period.		

Division of Health Service Regulation

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

TITLE

(X6) DATE

STATE FORM

6899

MNFQ11

If continuation sheet 1 of 49

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

STREET ADDRESS, CITY, STATE, ZIP CODE

JEFFERSON FAMILY CARE HOME #4

495 STALEY BOSWELL ROAD

YANCEYVILLE, NC 27379

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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	Monitoring and Follow-Up: - Internal Monitoring: - The facility will implement a weekly review of all communications with DHSR to ensure that there are no outstanding or missing notices related to regulatory compliance. - The admissions process will be monitored monthly to ensure that no unauthorized admission occurs. - Ongoing Compliance Checks: - The facility will schedule monthly internal audits to ensure that all policies and procedures are followed, including the Suspension of Admissions policy and the tracking of communications from DHSR. - An external auditor or consultant may be engaged to review compliance and provide recommendations on further improvements. Completion Date for Corrective Actions: 2/25/2025 By implementing these corrective actions, the facility aims to ensure full compliance with DHSR regulations and prevent future violations, thereby improving the overall health, safety, and welfare of the residents in care	2/25/2025

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 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	1. Immediate Corrective Action: a. Staff Training: All staff will be immediately trained on the importance of prompt and consistent evacuation assistance for residents, particularly those with cognitive impairments, such as Resident #5. b. Immediate Action during Next Fire Drill: During the next scheduled fire drill, Resident #5 will not be given direct assistance by staff to ensure proper evacuation. The supervisor-in-charge (SIC) will closely monitor Resident #5's evacuation and document any necessary interventions. c. Documentation: The fire drill logs will be updated to include the names of residents, including Resident #5, who participate in the drill, the total time taken for evacuation, and any relevant observations during the drill (such as whether additional assistance was needed for any resident). Resident #5 was discharged from the facility 2/24/25		4/7//2025
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	2. Long-Term Corrective Action: a. Revised Fire Drill Procedures: The facility will revise its fire drill procedures to ensure that all residents, especially those with cognitive impairments, are prompted not prompted and assisted as necessary during fire drills. Staff will be required to document each resident's participation and the evacuation time for each drill. <i>Revised via telephone with the Assitant Administrator on 03/27/25. PD</i> b. Fire Drill Logs Review: A designated staff member will be assigned to review fire drill logs monthly to ensure accurate documentation, including the participation of all residents and the evacuation time for each drill. c. Periodic Drills: The facility will conduct fire drills at different times of the day and night to ensure that residents are familiar with evacuation procedures under various circumstances. Special attention will be given to residents like Resident #5, who may require additional prompts during drills. d. Resident-Specific Evacuation Training: All residents with cognitive impairments will have an individualized evacuation plan created and maintained. This plan will be reviewed during the monthly fire drills to ensure it is still effective and up to date.		

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 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	Monitoring and Quality Assurance: a. Supervision of Fire Drills: The Administrator and/or SIC will conduct an audit of each fire drill to ensure compliance with the new evacuation procedures. This audit will include checking that Resident #5 is properly assisted and safely evacuated, and that all required documentation is completed accurately. b. Resident and Staff Feedback: The facility will incorporate feedback from both staff and residents after each fire drill to identify any issues or improvements needed in the evacuation process, particularly for residents who may require special assistance, such as Resident #5. Correction Date: The facility will complete the actions described above by April 7, 2025. Responsible Party: • Administrator • Supervisor-in-Charge (SIC) Completion Verification: • The Administrator will verify the completion of staff training, the development of individual evacuation plans, and the implementation of new fire drill procedures. • The facility will submit documentation of the updated fire drill logs and staff training records to the regulatory body by April 7, 2025, to demonstrate compliance with the Plan of Correction. This plan of correction will ensure that all residents, including those with cognitive impairments like Resident #5, are safely and independently able to evacuate during fire drills and in the event of an emergency		4/7/2025

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 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			

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 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			

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 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			

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 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			

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 022	Continued From page 8 2025.	C 022	Immediate Actions Taken:		2/25/2025
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	Resident #2: On 02/20/25, the SIC took Resident #2's blood pressure and documented the result (119/78). The order for daily blood pressure checks was reviewed and confirmed in the FL-2, with a clear plan to ensure that this order is followed moving forward. Resident #3: On 02/20/25, the SIC took Resident #3's blood pressure and documented the result (142/92). The order for twice-daily blood pressure checks was reviewed and confirmed in FL-2, with a clear plan to ensure that this order is followed moving forward. 2. Systemic Changes and Corrective Actions: - Review and Update of Orders: The facility will immediately review the current FL-2 forms for all residents to ensure that physician orders for blood pressure checks (and other medical orders) are clearly documented and followed. Any discrepancies or unclear orders will be immediately clarified with the primary care provider. - Blood Pressure Checks Documentation: A new, standardized procedure will be implemented for the documentation of blood pressure checks. All blood pressure checks will be documented on the MAR or blood pressure log, as appropriate. A specific section for "Blood Pressure Check Results" will be added to the MAR to ensure that these checks are documented daily for any resident with orders for frequent monitoring once or twice daily. - Staff Education and Training: All nursing staff, including the SIC, will receive training on the importance of adhering to physician orders for blood pressure checks. This training will include: - Understanding the importance of accurate and timely documentation. - Procedures for ensuring all orders are followed and clearly understood. - The process of communicating any discrepancies in orders to the physician for clarification. This training will be completed by [2/25/2025], and refresher courses will be conducted quarterly. - Supervision and Monitoring: The Administrator and Executive Director will conduct more frequent audits to ensure that blood pressure checks are being done according to orders. These audits will include: - Monthly reviews of the MAR for each resident to ensure blood pressure checks are being completed as per the physician orders. - Random audits of the blood pressure log and MARs to verify that blood pressure checks and results are documented. Any deviations or missed documentation will be addressed immediately.		

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 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	• Communication with Primary Care Providers: The facility will establish a protocol for communicating any concerns regarding physician orders. If an order is unclear or cannot be followed, the facility will reach out to the primary care provider to clarify and confirm orders. This will be done within 24 hours of identifying an issue. 3. Monitoring of Corrective Actions: • Monitoring by Administrator: The Administrator will conduct monthly audits of the MAR for all residents with orders for blood pressure checks. These audits will verify that checks are completed as ordered and documented properly. • Monthly Supervisor Reviews: The SIC will review the FL-2 forms for each resident under their care, ensuring that the orders for blood pressure checks are being followed. Any deviations will be addressed with immediate corrective actions. • Resident Care Meetings: During monthly care plan meetings, the interdisciplinary team will review the medical orders for each resident, ensuring that all orders, including blood pressure checks, are accurately followed and documented. 4. Responsible Parties: • Administrator: Oversee the review of FL-2s and implementation of corrective actions. Ensure regular audits and oversight of blood pressure checks. • SIC (Supervisor-in-Charge): Ensure blood pressure checks are completed as ordered and documented daily (or twice daily as required). Verify that all orders are clearly understood and followed. • Staff: Complete and document blood pressure checks accurately according to the physician's orders. Participate in ongoing training and audits to ensure compliance. • Executive Director: Ensure that the Administrator is following up on audits and reviewing any discrepancies in the orders or documentation. Timeframe for Completion: • Immediate corrective actions (blood pressure checks and documentation) will be completed by 02/25/25. • Staff education will be completed by 03/05/25. • Ongoing audits and reviews will begin immediately and continue monthly. 6. Conclusion: The facility takes the deficiencies identified seriously and is committed to providing safe, accurate, and compassionate care for all residents. The corrective actions outlined above will ensure that all blood pressure checks are conducted and documented according to physician orders, and that staff are properly educated and monitored to prevent recurrence of these issues.		2/25/2025

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 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			

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 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			

Division of Health Service Regulation

STATE FORM

6899

MNFQ11

If continuation sheet 12 of 49

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 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			

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 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	Plan of Correction: Review and Update of LHPS Evaluations: The facility will review all current LHPS evaluations to ensure that all necessary tasks are outlined and completed, especially regarding FSBS checks. A new LHPS evaluation for Resident #1 will be obtained and completed by the Primary Care Provider (PCP) to include specific tasks related to FSBS monitoring. The tasks will specify that FSBS checks are to be done twice weekly by facility staff, in compliance with the order on the FL-2. The PCP will be notified of this requirement immediately, and the completed evaluation will be obtained and documented by [2/25/2025]. The facility will establish a system to ensure that LHPS evaluations for all residents are completed quarterly, with specific tasks for any required medical procedures, including FSBS checks.		2/25/2025
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	Documentation and Monitoring of FSBS Checks: The facility will ensure that FSBS checks are documented correctly in Resident #1's MAR (Medication Administration Record) as prescribed. This includes both the documented twice-daily checks, which were being done by Resident #1 himself, and the twice-weekly checks to be done by facility staff as per the FL-2 order. All FSBS checks will be recorded in the appropriate logs, and any discrepancies between actual practices and documented orders will be immediately addressed. The facility staff will be trained to ensure that FSBS checks are completed by designated personnel according to the facility's policies and the physician's orders, rather than by residents themselves. Staff Training and Accountability: All facility staff involved in care and documentation of FSBS checks will undergo training to ensure full understanding of the procedures for monitoring FSBS, as well as the importance of documenting results accurately. The staff will be trained to verify that all medical orders, including those related to FSBS checks, are being followed and documented appropriately. The Administrator, Assistant Administrator, and Supervisor-in-Charge will be responsible for overseeing that staff adhere to these policies and that all tasks related to FSBS checks are completed as required. Regular audits of resident care plans, MAR documentation, and LHPS evaluations will be implemented to ensure compliance with established care protocols. Review of Current Policies and Procedures: The facility will conduct a comprehensive review of current policies and procedures regarding LHPS evaluations, FSBS monitoring, and the documentation of medical care tasks. Any gaps identified during this review will be addressed, and new policies will be implemented to ensure that future evaluations are comprehensive and aligned with the physician's orders. This includes ensuring that LHPS tasks are checked and appropriate for each resident's individual needs. The facility will review the current process for communicating between the facility and PCPs to ensure that all required medical evaluations and tasks are clearly communicated and addressed.		

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 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	Ongoing Monitoring and Quality Assurance: A designated Quality Assurance (QA) team will be responsible for monitoring compliance with these corrective actions. This includes verifying that FSBS checks are being completed as ordered and that LHPS evaluations include the necessary tasks for each resident. The facility will perform monthly audits of FSBS documentation and LHPS evaluations for the next three months. The results of these audits will be reviewed by the Administrator and shared with the Executive Director for further quality assurance and improvements as necessary. Date of Completion for Corrective Actions: All corrective actions will be implemented and completed by [2/25/2025].	

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 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			

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 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			

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 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			

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 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	Corrective Actions: - Menu Posting Compliance: - Immediate Action: The SIC will post the weekly and daily menu in a visible location in the kitchen by 02/22/25 to ensure compliance with facility policies. - Responsibility: Supervisor-in-Charge (SIC) - Timeline: Menu will be posted immediately, with weekly checks to ensure continuous compliance. - Training and Reinforcement of Menu Adherence: - Immediate Action: The SIC will attend a retraining session on 02/23/25 to reinforce the importance of following the cycle menu and posting it. This will include understanding the cycle menu, how to prepare meals accordingly, and ensuring that the meals served match the posted menu. - Additional Action: A meeting with the Administrator will be scheduled on 02/23/25 to review expectations regarding adherence to the menu, meal monitoring, and the process for reporting any deviations. - Responsibility: Supervisor-in-Charge (SIC), Administrator, and Executive Staff - Timeline: Completion by 02/23/25 - Administrator's Increased Oversight: - Immediate Action: The Administrator will begin conducting weekly reviews of meals served to ensure the SIC is adhering to the posted menu and that meals align with the cycle menu. - Additional Action: The Administrator will visit the kitchen at least once a week to observe the meals being served, starting 02/25/25, and ensure that the menu is posted and followed. - Responsibility: Administrator - Timeline: Ongoing weekly monitoring, with the first review on 02/25/25. - Resident Awareness: - Immediate Action: The Administrator will work with the SIC to ensure that the residents are informed about the weekly menu. This will include training for the SIC on how to verbally communicate the menu to residents who inquire about the meals. - Additional Action: A reminder to residents about the menu will be included in monthly meetings or meal-time communications starting 03/01/25 to ensure residents know the meals being served each day. - Responsibility: Administrator, Supervisor-in-Charge (SIC) - Timeline: Ongoing with first reminder by 03/01/25. - Review and Corrective Action Monitoring: - Immediate Action: The Administrator and Executive will conduct a follow-up review of the kitchen and meals served on 03/02/25 to ensure that the corrective actions have been implemented successfully. This will include verifying that the menu is posted and meals align with the posted menu. - Responsibility: Administrator, Executive Staff - Timeline: Follow-up review by 03/02/25. Root Cause The issue of the menu not being posted and the SIC not following the cycle menu was primarily due to a lack of monitoring and oversight from the Administrator. Additionally, there was a breakdown in communication regarding the expectations of menu adherence, leading to a failure in posting and preparing meals according to the planned cycle menu.	2/23/2025

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 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	Preventative Measures: 1. Ongoing Training: The SIC will undergo periodic training, including menu planning, meal preparation according to dietary guidelines, and menu posting. 2. Administrator Monitoring: The Administrator will ensure that the meal service is regularly monitored to confirm that the cycle menu is being adhered to, with monthly reviews in addition to regular oversight. 3. Menu Verification and Feedback: The residents will be encouraged to provide feedback on meal services during monthly meetings, which will be reviewed by the Administrator to ensure meal variety and satisfaction. Conclusion: The facility will implement corrective actions to address the absence of the menu posting and the non-compliance with the cycle menu. The Administrator will oversee these actions to ensure long-term compliance, and regular monitoring will be established to prevent future occurrences.	2/23/2025

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 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	Immediate Corrective Actions • Therapeutic Diet Training for Staff: o By [2/25/2025], conduct mandatory training for all kitchen and dietary staff on the importance of following therapeutic diets and the process for ensuring correct meal preparation in accordance with individual dietary restrictions. o Provide specific training on low sodium diets, including guidelines on sodium content and food preparation techniques to ensure compliance with dietary orders. • Availability of Menus and Diet Information: o By [2/25/2025], ensure that a therapeutic diet menu is always available in the kitchen for the SIC and kitchen staff to reference when planning and preparing meals. o The facility will create and post a clear and easily accessible dietary reference in the kitchen that includes all therapeutic diet orders, including low sodium diets, for each resident. • Review of Resident #3's Diet Order: o Verify Resident #3's low sodium diet order with their primary care provider (PCP) by [2/25/2025] and ensure the order is accurately documented in the facility's medical records and communicated to all relevant staff. o The Administrator will confirm that dietary restrictions are reviewed and understood by all kitchen and medical staff responsible for Resident #3's care.	2/25/2025
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	3. Systemic Changes to Prevent Recurrence • Implementation of Diet Menu Verification: o By [2/25/2025], implement a daily menu verification process where the SIC and Administrator will cross-check the meal plan against the resident's dietary orders prior to meal preparation. This verification will ensure compliance with therapeutic diets. • SIC and Administrative Oversight: o By [2/25/2025], the Administrator and Assistant Administrator will conduct monthly audits of the meals served to residents, ensuring that all therapeutic diets are followed, including proper sodium levels in meals. o The SIC will be required to submit weekly reports to the Administrator detailing any special dietary needs and compliance with therapeutic diet orders. • Ongoing Monitoring and Audits: o By [2/25/2025], the facility will implement an ongoing system of meal audits and training updates to ensure staff are consistently following therapeutic diet guidelines. Audits will be conducted quarterly, with findings reviewed by the Executive Director and Administrator.	

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 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	Responsible Party • Administrator: Oversight of training, verification of diet orders, and facility-wide compliance with therapeutic diet guidelines. • SIC: Responsible for ensuring compliance with therapeutic diet orders during meal planning and preparation. • Kitchen Staff: Adherence to therapeutic diet menus and proper meal preparation in line with dietary orders. 5. Monitoring and Follow-Up • Weekly Staff Check-Ins: The Administrator will hold weekly meetings with the kitchen staff to discuss compliance with dietary orders and address any issues or concerns. • Resident and Family Feedback: The Administrator will encourage Resident #3 and other residents to provide feedback regarding meals to ensure satisfaction and adherence to dietary needs. • Monthly Audits: The Administrator will conduct monthly audits of the therapeutic diet menu to ensure continued compliance and effectiveness in providing the correct meals to all residents. 6. Conclusion This Plan of Correction outlines corrective actions to ensure that Resident #3 and other residents receive meals that comply with their dietary needs, including the low sodium diet. The facility will implement training, system updates, and continuous monitoring to prevent future noncompliance. These corrective actions will be reviewed and assessed regularly to ensure effectiveness. This plan outlines the steps that the facility will take to address the violation and ensure future compliance with therapeutic diet orders.	2/25/2025

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 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			

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 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	Immediate Actions: Correction of Diet List: The diet list in the kitchen will be immediately updated to reflect accurate information. This includes the removal of any residents who no longer reside at the facility, as well as the addition of residents currently at the facility. The diet list will also accurately reflect all therapeutic diet orders. Specifically, Resident #2, who was incorrectly listed as having a No Concentrated Sweets (NCS) diet, will have their entry updated to reflect their physician-ordered regular diet, in accordance with their current FL-2. Resident #3, who was incorrectly listed as having a low sodium diet, will have their entry corrected to reflect their regular diet as confirmed by the SIC and their FL-2. Verification of Diet Orders: o The Supervisor-in-Charge (SIC), Administrator, and Executive Director will conduct a thorough review of each resident's diet orders and FL-2s to ensure that all therapeutic diets are correctly reflected on the diet list. o For all residents, an up-to-date FL-2 will be used as the primary reference for diet orders, and no resident will be assigned to a therapeutic diet unless there is a corresponding physician order. 2. Staff Education: * Training for the Supervisor-in-Charge (SIC) and Dietary Staff: o The SIC and all dietary staff will undergo training on the importance of maintaining an accurate and current diet list, which will be updated whenever there is a change in a resident's diet order, admission, or discharge. o Staff will be instructed to check both the diet list and FL-2s regularly to ensure compliance with physician orders. o The SIC will be trained to ensure that all therapeutic diets are followed properly, and that all required documentation, such as physician orders for therapeutic diets, is on file and up to date. * Training for the Administrator and Executive Director: o The Administrator and Executive Director will be trained on their roles and responsibilities in maintaining the accuracy of the diet list, specifically in ensuring that it is regularly updated to reflect changes in diet orders, admissions, or discharges. o They will also be instructed to monitor the facility's meals to ensure that the correct therapeutic diets are being served as per the residents' orders. 3. Ongoing Monitoring: * Diet List Updates: o A system will be implemented to ensure that the diet list is updated immediately following any changes to a resident's diet, admission, or discharge. This update will be monitored by both the Administrator and Executive Director. o The SIC will verify and update the diet list each time there is a change in diet orders or new FL-2s are received.	2/22/2025

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 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	• Verification of Meal Service: - o The Administrator and Executive Director will conduct regular checks at mealtimes to ensure that residents are receiving the correct meals according to their therapeutic diets. This will include random checks and verification that the correct meal is served to the correct resident. - o The SIC will be responsible for verifying that dietary staff are following the updated diet list and serving meals based on the appropriate therapeutic diet orders. 4. Documentation: • Daily Review: - o The Administrator will implement a daily review of the diet list to ensure any updates to the list are made promptly and accurately. - o The SIC will review the diet list each morning before meal preparation and service to confirm the accuracy of diet orders for all residents. 5. Timetable for Implementation: • Immediate Action: - o The diet list will be corrected and updated no later than 02/22/25. • Staff Training: - o Staff training will be completed by 02/28/25. • Ongoing Monitoring: - o Monitoring will begin immediately and continue daily, with monthly reviews of the diet list and meal service conducted by the Administrator and Executive Director.	2/22/2025	

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 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		

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 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			

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 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	Immediate Corrective Actions: - Review of Current Orders: o A complete review of Resident #1's FL-2, MAR, and FSBS orders will be conducted by the Assistant Administrator and Administrator to ensure that all orders are consistent. - o A meeting with the PCP will be arranged to clarify the appropriate frequency of FSBS checks for Resident #1. - o Any incorrect or outdated entries in the MAR will be corrected, and the pharmacy will be contacted to remove any discontinued or inaccurate orders. - Communication with Pharmacy: o The Administrator will contact the pharmacy to verify the current and correct FSBS order for Resident #1 and ensure only the accurate order is reflected on the MAR. - Updated FSBS Schedule: If the PCP orders FSBS checks twice weekly, the MAR will be updated to reflect this order, and the twice-daily entry will be discontinued immediately. - Education and Training: All clinical staff will be educated on the importance of verifying the correct orders in both the FL-2 and the MAR and ensuring that all entries are consistent. A review of the proper procedures for handling discrepancies in medication orders will be conducted with all nursing and supervisory staff. - Monitoring and Compliance: The Administrator will conduct weekly audits for the next 30 days to ensure that the FSBS orders are followed correctly. Any discrepancies or failures to follow proper procedures will be addressed immediately through corrective action plans. 4. Systemic Changes to Prevent Recurrence: - Monthly Review of FL-2 and MAR: The Assistant Administrator will implement a monthly review process where the FL-2 and MAR are compared for accuracy before being finalized. Any discrepancies between the FL-2 and MAR will be addressed immediately to ensure consistency.	2/25/2025	

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 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	Improved Communication Process: A communication protocol will be established to ensure that all changes or updates to care orders are communicated to all relevant parties, PCP, staff, Administrator, pharmacy). The SIC will be required to confirm with the Administrator or pharmacy whenever there is any ambiguity in care orders, including FSBS checks, to avoid errors in documentation. Audits: Regular audits of MARs, FSBS logs, and care orders will be conducted monthly by the Administrator, with any discrepancies addressed promptly. A standardized checklist will be developed to help staff identify potential discrepancies and errors during routine care documentation audits. 5. Long-Term Goals: - Ensure that care orders are clear, accurate, and consistently followed by all staff. - Improve communication channels between all parties involved in resident care to prevent errors. - Achieve 100% compliance with accurate documentation on the MAR and FL-2 for all care orders. 6. Accountability: - The Assistant Administrator will oversee the implementation of the plan of correction and ensure compliance with all corrective actions. - The Administrator will monitor the completion of all corrective actions and conduct regular audits to ensure that issues related to FSBS order discrepancies do not recur. - Staff will be held accountable for following all policies and procedures regarding medication orders, documentation, and communication. By following this plan of correction, we will ensure that Resident #1 receives the appropriate frequency of FSBS checks and that any discrepancies are resolved in a timely and systematic manner.	2/25/2025	

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 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	Immediate Actions Taken 1. Paliperidone Injection (Antipsychotic Medication) a. Action: Immediately scheduled and administered Resident #1's overdue paliperidone injection (819mg/2.63mL) as ordered by the mental health provider (MHP). b. Responsible Party: Supervisor-in-Charge (SIC) and MHP. c. Verification: Documented administration in the Medication Administration Record (MAR) and Health Services Report. 2. Cefalexin (Antibiotic Medication) a. Action: Immediately contacted the pharmacy to verify the availability of cefalexin 500mg and ensured that the antibiotic was administered to Resident #1 according to the physician's order. b. Responsible Party: SIC, Pharmacy, and Administrator. c. Verification: Documented administration of cefalexin on the MAR. II. Root Cause Analysis 1. Paliperidone Injection a. Issue: Documentation gaps and communication breakdowns led to the failure to administer the paliperidone injection timely. b. Contributing Factors: Lack of communication between the MHP, SIC, and Administrator regarding the administration and documentation of the injection. Failure to verify that the medication was administered on the MAR and ensure that doses were provided on time. 2. Cefalexin Prescription a. Issue: Delayed transmission of the cefalexin order to the pharmacy, resulting in a 22-day delay in the medication being filled and administered. b. Contributing Factors: Administrative delays in faxing the medication order from the SIC to the pharmacy. Failure to document the order on the MAR after the medication was administered.	4/7/2025

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 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	III. Corrective Actions I. Paliperidone Injection a. Action: Implement a new protocol for communication between MHP, SIC, and Administrator regarding medication orders and administration. Ensure that the injection administration is documented on both the MAR and the Health Services Report immediately after administration. Establish a system of regular audits to verify that injections are administered on time. Review medication administration records monthly to ensure compliance with treatment schedules. Provide training for all staff on the importance of documenting the medication administration on both the MAR and in the health services reports. b. Responsible Party: SIC and Administrator. c. Timeline: Full compliance by April 7, 2025. Cefalexin Prescription d. Action: Ensure that all medication orders, especially those from hospitals, are faxed to the pharmacy immediately upon receipt of the after-visit report, or the next available business day. Implement a process to verify that all medication orders are accurately transcribed onto the MAR prior to administration. Establish a policy that requires SIC to follow up with the pharmacy within 24 hours to ensure timely dispensing of medications. Train all staff on the importance of timely and accurate faxing of medication orders to prevent delays.	4/7/2025	
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			

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 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	Responsible Party: SIC, Administrator, and Pharmacy. Timeline: Full compliance by April 7, 2025. IV. Preventive Actions 1. Paliperidone Injection a. Action: Develop a medication tracking system that includes a checklist for scheduled injections, which will be completed by the SIC and reviewed by the Administrator. Perform monthly audits of medication administration for residents receiving long-acting injections, with documentation of injection administration and review of MAR for accuracy. Ensure all staff members are trained in the new medication tracking and auditing systems to ensure timely administration. 2. Cefalexin Prescription a. Action: Update procedures for managing hospital discharge medications to ensure that all medication orders are immediately faxed to the pharmacy upon receipt. Implement a process for confirming receipt of orders by the pharmacy and confirming the expected date of delivery to ensure no delays in medication administration. Conduct regular training for staff on hospital discharge and medication administration protocols to avoid delays in treatment. V. Monitoring and Follow-Up 1. Ongoing Monitoring: a. A designated staff member (SIC or Administrator) will be assigned to ensure that the corrections outlined in this plan are implemented and adhered to. b. Monthly audits will be conducted on the MARs to confirm that medications are being administered as ordered and documented accurately. 2. Follow-Up Meetings: a. The Administrator and SIC will meet weekly for the next 4 weeks to review the implementation of the corrective actions and adjust as needed. b. Any issues identified during the monitoring process will be addressed immediately to ensure compliance. 3. Reporting: a. The Administrator will submit monthly reports to the governing body outlining the status of compliance with this Plan of Correction and any corrective actions taken. VI. Conclusion The facility recognizes the failure to administer and document medications as ordered for Resident #1 and is committed to implementing these corrective actions to prevent recurrence. These steps will ensure that Resident #1 receives medications as prescribed, and that all documentation is accurate and timely. Compliance with these corrective actions will be verified by April 7, 2025.	4/7/2025

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 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		

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 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		

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 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			

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 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			

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 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			

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 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			

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 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		

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 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			

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 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			

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 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	Immediate Actions Taken: • Immediate Retrieval of Missing Documents: As of 02/20/25, the Administrator has instructed the Assistant Administrator to immediately retrieve all missing physician's orders, care plans, and FL-2 forms for Residents #1, # 2, 3, and #5 from the main office and ensure that these documents are filed in the appropriate resident records. • Immediate Staff Training: On 02/20/25, the Supervisor-in-Charge (SIC), Assistant Administrator, and other relevant staff members will undergo an in-service training regarding the importance of promptly filing all required documents (FL-2 forms, care plans, and physician orders) in the resident records. This training will also include proper procedures for handling, storing, and reviewing resident records. 2. Systematic Corrections: • Review of Documentation Protocols: The Administrator and Executive Director will review and revise the facility's current protocols for ensuring that all physician orders, care plans, and FL-2 forms are accurately documented and filed in resident records. This review will ensure that all documents are filed within one week of the PCP's visit. • Revise Record Audit Process: The Administrator will enhance the monthly record audit process. This revised process will include: o Verification that all care plans, FL-2s, and physician orders are filed and up to date. o A documented checklist and a follow-up procedure for any missing documentation, ensuring that all required documents are received from the main office and entered the system promptly. o The Executive Director will review the audit results monthly to ensure compliance with the revised process. • Improved Communication with PCP Office: The facility will implement a formalized communication protocol with the PCP's office to ensure that all signed FL-2s, care plans, and physician orders are sent directly to the facility within one week of the PCP's visit. The Assistant Administrator will be responsible for confirming receipt of these documents and will immediately file them upon arrival.	3/15/2025

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 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	Corrective Action for Individual Residents: - Resident #1, #2, 3, and #5: - o Immediate Updates: All missing FL-2 forms, care plans, and physician orders for Residents #1, #2, 3, and #5 will be retrieved, reviewed for accuracy, and placed into the appropriate resident records no later than [Insert Date]. - o Follow-Up: The Administrator will ensure that future care plans and physician orders for these residents are updated as needed and filed within the required time frame. 4. Long-Term Prevention Strategies: - Enhanced Staff Accountability: - o The Assistant Administrator will implement a daily checklist for reviewing resident records to ensure that all newly signed FL-2 forms, care plans, and physician orders are filed. This checklist will be signed and dated by the staff member responsible at the end of each day. - o The Supervisor-in-Charge (SIC) will conduct random weekly audits of resident records to ensure compliance with documentation and filing procedures. - Quarterly Record Review: - The Administrator will conduct a quarterly review of the facility's documentation and filing system to ensure ongoing compliance with regulations and the timely entry of documents into resident records. This review will be documented, and corrective actions will be implemented as needed. - Ongoing Staff Education: - Ongoing education will be provided to all facility staff on the importance of accurate recordkeeping, the role of care plans, FL-2 forms, and physician orders, and the impact of these documents on resident care. This will include regular in-service training every six months, or as needed, based on findings from audits or issues identified during staff interviews. 5. Monitoring and Compliance: - The Administrator will be responsible for monitoring the completion of the corrective actions outlined above and will submit a progress report to the Executive Director every 30 days until all issues are resolved. - The Executive Director will review progress reports and, if necessary, will make additional recommendations for improvements to ensure compliance with all applicable regulations.		3/15/2025

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 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	Responsible Parties: Administrator Assistant Administrator • Supervisor-in-Charge (SIC) • Executive Director: 6. Verification of Completion: Upon the successful completion of the corrective actions, the Administrator will submit verification to the appropriate regulatory bodies confirming that all required documentation has been filed, and all systems are in place to ensure continued compliance. Additionally, the facility will maintain a record of all training and audits conducted as part of this plan. Administrator DAVID A HUMPHREY		3/15/2025

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

STREET ADDRESS, CITY, STATE, ZIP CODE

JEFFERSON FAMILY CARE HOME #4

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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		

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 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			

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 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			

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 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			

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 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			