

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER MILDRED'S FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3592 MARSHALL GRAVES 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 survey on 08/14/25.	C 000		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors that were accessible to a resident who was intermittently disoriented (#2) and a resident who was constantly disoriented (#3), had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Observation of the entrance/exit doors to the	C 069		

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

TITLE

(X6) DATE

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C 069	Continued From page 1 facility on 08/14/25 at various times between 8:30am-4:30pm revealed: -There was a large red alarm on the wooden exit doors. -There were no alarms on the storm doors. -No alarm sounded when the doors to the facility were opened and closed. Second observation of the entrance/exit doors to the facility on 08/14/25 at 4:34pm revealed: -The Supervisor-in-Charge (SIC) used a key to activate the red door alarm. -A loud, audible sound could be heard throughout the facility when the door was opened. -The alarm had to be turned off with the key. 1. Review of Resident #3's current FL2 dated 10/02/24 revealed: -Diagnoses included dementia, schizophrenia, and diabetes. -The resident was constantly disoriented. Review of Resident #3's care plan dated 06/05/25 revealed he was sometimes disoriented, forgetful and needed reminders. Interview with the SIC on 08/14/25 at 12:37pm revealed: -Resident #3's memory "comes and goes". -Resident #3 did not leave the facility grounds. -Resident #3 liked to sit outside and smoke. Interview with the Owner/SIC on 08/14/25 at 3:00pm revealed Resident #3 would not walk away from the facility. Telephone interview with the facility's primary care provider (PCP) on 08/14/25 at 2:33pm revealed: -Resident #3 had "his moments" related to being disoriented.	C 069		

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C 069	Continued From page 2 -Resident #3 had not walked away from the facility that she was aware of. Attempted telephone interview with Resident #3's guardian on 08/14/25 at 2:51pm was unsuccessful. 2. Review of Resident #2's current FL2 dated 10/18/24 revealed: -Diagnoses included dementia, schizophrenia, and diabetes. -The resident was constantly disoriented. Review of Resident #2's care plan dated 10/19/24 revealed he was sometimes disoriented, forgetful, and needed reminders. Telephone interview with Resident #2's family member on 08/14/25 at 5:10pm revealed: -Resident #2 had been disoriented for years. -He did not think Resident #2 needed supervision when he went outside of the facility. -He did not think Resident #2 "would go anywhere" if he stayed the same as he had been. -Resident #2 had been in facilities for over 25 years and had never had a problem. Interview with the SIC on 08/14/25 at 12:37pm revealed she had not seen any issues with Resident #2's memory. Interview with the Owner/SIC on 08/14/25 at 3:00pm revealed Resident #1 would not walk away from the facility. Telephone interview with the facility's primary care provider (PCP) on 08/14/25 at 2:33pm revealed Resident #2's memory was not bad; she did not have any concerns about the resident walking away from the facility.	C 069		

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C 069	Continued From page 3 Interview with the Owner/SIC on 08/14/25 at 10:18am revealed: -She turned the door alarms on when it got dark in the evenings, and she kept the front door alarm on until the residents ate breakfast. -The alarms were on the wooden doors, not the storm doors. -None of the residents had ever "walked off". -None of the residents needed supervision when they were outside. -She did not know the facility needed to have door alarms on the doors during the daytime hours. Telephone interview with the facility's PCP on 08/14/25 at 2:33pm revealed that all facilities needed door alarms in general to know when a resident went outside so staff could keep an eye on the residents. Telephone interview with the Administrator on 08/14/25 at 3:37pm revealed: -He was not sure the PCP had completed the FL2s correctly for the residents' orientation. -He did not have any concerns about the residents leaving the facility. -He was not aware that door alarms needed to always be turned on if a resident was deemed to be disoriented.	C 069		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	C 246		

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C 246	Continued From page 4 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to refer 3 of 3 sampled residents (#1, #2, #3), who were diabetic and needed their toenails trimmed to a podiatrist. The findings are: According to the American Diabetes Association, diabetes could cause nerve damage. Lost sensitivity in the feet could make it difficult to know if a person with diabetes was hurt or injured, and even the smallest cuts and scrapes could become difficult to heal. Calluses occurred more often and built up faster on the feet of people with diabetes. Calluses, if not trimmed, got very thick, broke down, and turned into ulcers (open sores). 1. Review of Resident #1's current FL2 dated 04/23/25 revealed diagnoses included schizophrenia, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). Review of Resident #1's care plan dated 04/23/25 revealed he required extensive assistance from staff with bathing, dressing, grooming, and personal hygiene. Review of Resident #1's podiatry after-visit summary dated 07/22/24 revealed the resident's toenails were debrided. Review of Resident #1's Licensed Health Professional Support (LHPS) assessment form dated 06/06/25 revealed: -Resident #1 had type II diabetes. -There was no documentation related to the resident's toenails.	C 246		

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C 246	Continued From page 5 Interview with Resident #1 on 08/14/25 at 12:22pm revealed: -His toenails needed to be cut. -His toenails hurt. -When he slid his foot "all the way" in his shoes (he had on slide-in shoes), he would have to pull his foot back out some, because his toenails hurt when they touched the end of the shoe. -He told the Supervisor-in-Charge (SIC) a couple of weeks ago that his toenails hurt. Observation of Resident #1's toenails on 08/14/25 at 12:22pm revealed: -The first toenail on his left foot was thick, discolored, and had curled completely over the end, and was pushing into the skin on the bottom of the toe -The second, third, and fourth toenails on the left foot were thick and black, curled into a cylinder shape, and were raised and twisted to the side. -The fifth toenail on his left foot had broken off, leaving an open dried nailbed. -The first toenail on his right foot was thick, brown in color, cracked, and had grown over the end of the toe, and was pushing into the side of the second toe and the bottom of the first toe. -The second and fourth toenails on his right foot were thick, black in color, and had grown over the end of the toe, pushing into the bottom of the toe. -The third toenail on his right foot was thick, black in color, and had grown over the end of the toe, pushing into the bottom side of the second toenail. -The fifth toenail on his right foot had broken off, leaving an open dried nailbed. Interview with the SIC on 08/14/25 at 1:23pm revealed: -She helped Resident #1 with his shower; she	C 246		

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C 246	Continued From page 6 washed his back. -Resident #1 washed his own feet. -Resident #1's toenails usually grew slowly. -She did not recall Resident #1 complaining that his toenails hurt. -She did not know Resident #1's toenails looked "so bad". -She had never seen toenails turn black. Telephone interview with a representative from Resident #1's podiatrist's office on 08/14/25 at 1:47pm revealed Resident #1 had not been seen by the podiatrist since 07/22/24. Telephone interview with Resident #1's primary care provider (PCP) on 08/14/25 at 2:55pm revealed: -No one had told her Resident #1's toenails needed to be cut. -Resident #1 had not complained to her about his toenails. Interview with the Owner/SIC on 08/14/25 at 3:00pm revealed that she had not seen Resident #1's toenails. Refer to the interview with the SIC on 08/14/25 at 1:23pm. Refer to the telephone interview with the LHPS nurse on 08/14/25 at 1:31pm. Refer to the telephone interview with a representative from the podiatrist's office on 08/14/25 at 1:47pm. Refer to the telephone interview with the facility's PCP on 08/14/25 at 2:55pm. Refer to the interview with the Owner/SIC on	C 246		

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C 246	Continued From page 7 08/14/25 at 3:00pm. Refer to the telephone interview with the Administrator on 08/14/25 at 3:37pm. 2. Review of Resident #2's current FL2 dated 10/18/24 revealed diagnoses included diabetes, schizophrenia, hypertension, and dementia. Review of Resident #2's care plan dated 10/19/24 revealed he required extensive assistance from staff with bathing, dressing, grooming, and personal hygiene. Review of Resident #2's podiatry after-visit summary dated 10/09/24 revealed: -There were directions to apply an antibiotic ointment to ulcers on the left foot and right lower leg daily. -There was also an order for two oral antibiotics. Review of Resident #2's Licensed Health Professional Support (LHPS) assessment form dated 06/06/25 revealed there was no documentation related to the resident's toenails. Observation of Resident #2's feet on 08/14/25 at 12:26pm revealed: -Both of his feet were dry and scaly. -The first, second, and third toenails on his right foot were broken and jagged. -The fourth toenail on his right foot was growing into the toe bed and had a build-up of dead skin. -The fifth toenail on his right foot had grown past the end of the toe and was broken; there was dead skin around the base of the toenail. -The first toenail on his left foot was thick, brown in color, cracked, and was beginning to curl, which made the right corner of the toenail push down into the toe.	C 246		

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C 246	Continued From page 8 -The second toenail on his left foot was thick and rippled and was growing toward the first toe. -The third toenail on his right foot had grown past the end of the toe and was jagged and sharp. -The fourth toenail on his right foot had broken off and had dried blood on the nail bed. -The fifth toenail on his right foot had grown past the end of the foot and had turned to the left side of his foot. Interview with Resident #2 on 08/14/25 at 12:25pm revealed: -Sometimes, the staff helped him with this shower. -His toenails needed to be cut. -His toenails hurt in "tight" shoes. -A podiatrist cut his toenails, but he did not recall the last time his toenails were cut. Interview with the Supervisor-in-Charge (SIC) on 08/14/25 at 1:23pm revealed: -She helped Resident #2 with his shower; she washed his back. -Resident #2 washed his own feet. -Resident #2 had not complained to her that his toenails hurt. Telephone interview with a representative from Resident #2's podiatrist's office on 08/14/25 at 1:47pm revealed Resident #2 had not been seen by the podiatrist since 10/09/24. Telephone interview with Resident #2's primary care provider (PCP) on 08/14/25 at 2:55pm revealed: -No one had told her Resident #2's toenails needed to be cut. -Resident #2 had a history of ulcers on his feet and was at risk of infections.	C 246		

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C 246	Continued From page 9 Interview with the Owner/SIC on 08/14/25 at 3:00pm revealed: -She had not seen Resident #2's toenails. -Resident #2 had ulcers on his feet in the past. Refer to the interview with the SIC on 08/14/25 at 1:23pm. Refer to the telephone interview with the LHPS nurse on 08/14/25 at 1:31pm. Refer to the telephone interview with a representative from the podiatrist's office on 08/14/25 at 1:47pm. Refer to the telephone interview with the facility's PCP on 08/14/25 at 2:55pm. Refer to the interview with the Owner/SIC on 08/14/25 at 3:00pm. Refer to the telephone interview with the Administrator on 08/14/25 at 3:37pm. 3. Review of Resident #3's current FL2 dated 10/02/24 revealed diagnoses included diabetes, schizophrenia, dementia, and hypertension. Review of Resident #3's care plan dated 06/05/25 revealed he required extensive assistance from staff with bathing, dressing, grooming, and personal hygiene. Review of Resident #3's podiatry after-visit summary date 07/22/24 revealed the resident's toenails were debrided. Review of Resident #3's Licensed Health Professional Support (LHPS) assessment form dated 06/06/25 revealed there was no	C 246			

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C 246	Continued From page 10 documentation related to the resident's toenails. Observation of Resident #3's feet on 08/14/25 at 12:33pm revealed: -There was scaly, flaking, peeling skin on the top of his left and right foot. -There was a buildup of dark colored debris and thick dried skin under and between his toes on the bottom of his left foot. -The first toenails on his left and right feet were thick, discolored brown, and had raised into a hump on the nail beds. -The second, third, fourth, and fifth toenails on both feet were thick, had grown over the end of the toes, and curled under the end of the toes. Interview with Resident #3 on 08/14/25 at 12:33pm revealed: -His toenails needed to be cut. -His toenails hurt. -He pointed toward his first toe on his right foot and stated that it hurt. -He could not be redirected to further discuss his toenails. Interview with the Supervisor-in-Charge (SIC) on 08/14/25 at 1:23pm revealed: -She helped Resident #3 with his shower. -She had to bathe "all" of Resident #3. -The podiatrist had said to keep Resident #3's feet clean and dry. Telephone interview with a representative from Resident #3's podiatry office on 08/14/25 at 1:47pm revealed Resident #3 had not been seen by the podiatrist since 07/22/24. Telephone interview with Resident #3's primary care provider (PCP) on 08/14/25 at 2:55pm revealed:	C 246		

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C 246	Continued From page 11 -No one had told her Resident #3's toenails needed to be cut. -She was concerned there was a buildup of dark colored debris and thick dried skin under and between the resident's toes. Interview with the Owner/SIC on 08/14/25 at 3:00pm revealed she had not seen Resident #3's toenails. Refer to the interview with the SIC on 08/14/25 at 1:23pm. Refer to the telephone interview with the LHPS nurse on 08/14/25 at 1:31pm. Refer to the telephone interview with a representative from the podiatrist's office on 08/14/25 at 1:47pm. Refer to the telephone interview with the facility's PCP on 08/14/25 at 2:55pm. Refer to the interview with the Owner/SIC on 08/14/25 at 3:00pm. Refer to the telephone interview with the Administrator on 08/14/25 at 3:37pm. Interview with the SIC on 08/14/25 at 1:23pm revealed that the podiatrist did not want the residents to have a follow-up appointment until the toenails had "growth on the toenails" or if the resident complained of their toenails hurting. Telephone interview with the LHPS nurse on 08/14/25 at 1:31pm revealed: -She had not looked at the residents' feet/toenails when she was at the facility. -Residents who had a diagnosis of diabetes	C 246		

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C 246	Continued From page 12 should be seen by a podiatrist. -Long toenails could result in ingrown toenails and wounds. -Wounds were difficult to heal in people with diabetes. Telephone interview with a representative from the podiatrist's office on 08/14/25 at 1:47pm revealed: -If a diabetic resident's toenails were not cut, the resident was at risk for ingrown toenails, infections, and pain. -Infections that were not treated in a timely manner could spread into the bone and would increase the risk of amputation. -Residents who were diabetic needed to be seen by a podiatrist, usually every 3-4 months. Telephone interview with the facility's PCP on 08/14/25 at 2:55pm revealed that long toenails put the residents at risk for an infection, which could lead to amputation. Interview with the Owner/SIC on 08/14/25 at 3:00pm revealed: -The residents were supposed to see the podiatrist every 3 months. -The other SIC was responsible for making appointments for the residents to see the podiatrist. -Residents with diabetes could have neuropathy in their feet. -She was concerned the residents' toenails had not been cut because it could affect their health. Telephone interview with the Administrator on 08/14/25 at 3:37pm revealed: -Residents who were diabetic should go to the podiatrist. -He was concerned that a follow-up appointment	C 246		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246	Continued From page 13 had not been made for the residents to see the podiatrist. -If the residents' toenails were long and unkept, the residents were not going to the podiatrist often enough. The facility failed to refer 3 residents diagnosed with diabetes, who required toenail trimming, to a podiatrist. As a result, one of the resident's toenails had grown over the end of the toes, putting pressure on the bottom of the toes and on the sides of other toes, and other toenails were raised and twisted, and two toenails were broken completely off, leaving dried skin on the nail bed. The toenails were causing the resident pain (#1); a second resident, who had a history of foot ulcers, had broken and jagged toenails, and his feet were dry and scaly (#2); and a resident who had two toenails that were raised into a hump and were causing him pain (#3). This caused increased risk of injury and infection to the residents. This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/14/25 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 28, 2025.	C 246		
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	C 270		

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C 270	Continued From page 14 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 3 sampled residents (#1) with a physician's order for a low carbohydrate diet. The findings are: Observation of the kitchen on 08/14/25 at 1:13pm revealed: -There was a low-cholesterol/low-fat diet menu posted on the wall in the kitchen. -There was no menu posted for a low-carbohydrate diet. Review of Resident #1's current FL2 dated 04/23/25 revealed: -Diagnoses included schizophrenia, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). -There was no diet order. Review of Resident #1's Licensed Health Professional Support (LHPS) assessment form revealed Resident #1 had type II diabetes. Review of Resident #1's primary care provider (PCP) after-visit summary dated 06/18/25 revealed: -Resident #1's blood sugar was elevated.	C 270		

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C 270	Continued From page 15 -There was an order for a low-carbohydrate diet. Observation of the breakfast meal on 08/14/25 at 9:03am revealed that all the residents were served the same meal, which consisted of a bowl of cereal with sliced strawberries, scrambled eggs, two pieces of sausage, and a piece of toast. Interview with Resident #1 on 08/14/25 at 12:22pm revealed: -He was diabetic. -He was not on a special diet. -He ate whatever he was served. Interview with the Supervisor-in-Charge (SIC) on 08/14/25 at 4:08pm revealed that she did not see the order for a low-carbohydrate diet for Resident #1. Telephone interview with the Administrator on 08/14/25 at 3:37pm revealed: -The facility did not have a menu for a low-carbohydrate diet. -The facility had a menu for a no-concentrated sweet diet. -A staff member should have let the PCP know what therapeutic meals the facility could provide. Attempted telephone interview with Resident #1's (PCP) Primary Care Provider on 08/14/25 at 1:57pm was unsuccessful.	C 270			
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for	C 315			

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C 315	Continued From page 16 medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 sampled residents (#1, #3) regarding an order for a medication used to treat allergies, depression, high cholesterol, and blood pressure medication. The findings are: Review of Resident #1's current FL2 dated 04/23/25 revealed diagnoses included schizophrenia, hypertension, hyperlipidemia, and chronic obstructive pulmonary disease (COPD). a. Review of Resident #1's current FL2 dated 04/23/25 revealed an order for loratadine (used to treat allergies) 10mg one capsule daily. Review of Resident #1's signed 6-month physician's orders dated 04/23/25 revealed an order for loratadine 10mg two capsules daily. Review of Resident #1's care plan dated 04/23/25 revealed: -Resident #1's medications were listed on the care plan with an attachment of medications	C 315		

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C 315	Continued From page 17 signed by the primary care provider (PCP). -Loratadine 10mg was documented as 2 capsules once daily. Review of Resident #1's June 2025, July 2025, and August 2025 medication administration records (MAR) from 08/01/25-08/14/25 revealed: -There was an entry for Loratadine 10mg , take one tablet once daily with a scheduled administration time of 8:00am. -Loratadine 10mg was documented as administered daily. Observation of Resident #1's medications on hand on 08/14/25 at 1:00pm revealed: -The medication was dispensed in a multidose package -There was one tablet of loratadine 10mg in the multidose package. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/25 at 2:10pm revealed: -The current order on file for Resident #1's loratadine was dated 11/26/24 for 10mg, take one tablet once daily. -The pharmacy did not receive Resident #1's signed physician's order for loratadine 10mg, take two tablets once daily. -If the order was received for 2 tablets, the order would have been clarified as the dose was an unusual order. b. Review of Resident #1's current FL2 dated 04/23/25 revealed an order for lovastatin (used to treat high cholesterol) 40mg one capsule at bedtime. Review of Resident #1's signed 6-month physician's orders dated 04/23/25 revealed an	C 315		

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C 315	Continued From page 18 order for lovastatin 40mg take two capsules at bedtime. Review of Resident #1's care plan dated 04/23/25 revealed: -Resident #1's medications were listed on the care plan with an attachment of medications signed by the primary care provider (PCP). -Lovastatin 40mg was documented as 2 capsules at bedtime. Review of Resident #1's June 2025, July 2025, and August 2025 medication administration records (MAR) from 08/01/25-08/13/25 revealed: -There was an entry for lovastatin 40mg, take one tablet at bedtime with a scheduled administration time of 8:00pm. -Lovastatin 40mg was documented as one capsule administered at bedtime. Observation of Resident #1's medications on hand on 08/14/25 at 1:00pm revealed: -The medication was dispensed in a multidose package -There was one tablet of lovastatin 40mg in the multidose package. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/25 at 2:10pm revealed: -The current order on file for Resident #1's lovastatin was dated 11/04/24 for 10mg, take one tablet once daily. -The pharmacy did not receive Resident #1's signed physician's order for lovastatin 40mg, take two tablets once daily. -If the order was received for 2 tablets, the order would have been implemented as that dosage was not unusual.	C 315		

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C 315	Continued From page 19 c. Review of Resident #1's current FL2 dated 04/23/25 revealed an order for sertraline (used to treat depression) 25mg two capsules at bedtime. Review of Resident #1's signed 6-month physician's orders dated 04/23/25 revealed an order for sertraline 25mg one capsule at bedtime. Review of Resident #1's care plan dated 04/23/25 revealed: -Resident #1's medications were listed on the care plan with an attachment of medications signed by the primary care provider (PCP). -Sertraline 25mg was documented as 1 capsule at bedtime. Review of Resident #1's June 2025, July 2025, and August 2025 medication administration records (MAR) from 08/01/25-08/13/25 revealed: -There was an entry for sertraline 25mg, take one tablet at bedtime with a scheduled administration time of 8:00pm. -Sertraline 25mg was documented as one capsule administered at bedtime. Observation of Resident #1's medications on hand on 08/14/25 at 1:00pm revealed: -The medication was dispensed in a multidose package -There was one tablet of sertraline 25mg in the multidose package. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/25 at 2:10pm revealed: -The current order on file for Resident #1's sertraline was dated 01/21/25 for 25mg, take one tablet at bedtime. -The pharmacy did not receive Resident #1's signed physician's order for sertraline 25mg, take	C 315			

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C 315	Continued From page 20 two tablets at bedtime. -If the order was received for 2 tablets, the order would have been implemented as they would have thought it was a dose increase. d. Review of Resident #1's current FL2 dated 04/23/25 revealed: -There was an order for hydralazine (used to treat high blood pressure) 10mg take two capsules in the morning, and take one capsule at 2:00pm, and one capsule at bedtime. -There was an order for blood pressure checks three times a week. Review of Resident #1's signed 6-months physician's orders dated 04/23/25 revealed an order hydralazine 10mg: take two capsules in the morning, take one capsule at 2:00pm and one capsule at bedtime; there was no documentation about blood pressure checks or parameters. Review of Resident #1's care plan dated 04/23/25 revealed an order for hydralazine 10mg take two capsules in the morning, take one capsule at 2:00pm, and one capsule at bedtime; there was no documentation about blood pressure checks or parameters. Review of Resident #1's June 2025, July 2025, and August 2025 medication administration records (MAR) from 08/01/25-08/13/25 revealed: -There was an entry for hydralazine 10mg, take two tablets in the morning with a scheduled administration time of 8:00am, take one tablet twice daily, scheduled at 2:00pm and 8:00pm; hold for systolic blood pressure less than 100. -Hydralazine 10mg was documented as administered three times daily, two tablets at 8:00am, and one tablet at 2:00pm and 8:00pm.	C 315		

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C 315	Continued From page 21 Review of Resident #1's blood pressure log for June 2025, July 2025, and August 2025 from 08/01/25-08/14/25 revealed there were no systolic blood pressures documented as less than 100. Observation of Resident #1's medications on hand on 08/14/25 at 1:00pm revealed: -The medication was dispensed in a multidose package -There were two tablets of hydralazine 10mg in the multidose package for the morning dose, and one tablet of hydralazine 10mg in the package for the afternoon and the evening dose. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/14/25 at 2:10pm revealed: -The current order on file for Resident #1's hydralazine was dated 02/06/25 for 10mg, take two tablets in the morning and one tablet in the afternoon, and at bedtime, and hold for systolic blood pressure less than 100. -The pharmacy did not receive Resident #1's FL2 or signed physician's order with no parameter; had they received the order, the parameters would have been removed. Interview with the Supervisor-in-Charge (SIC) on 08/14/25 at 12:36pm revealed: -She filled in the FL2, and the primary care provider (PCP) reviewed and signed. -It was a clerical error -She filled in the FL2 based on the resident's current MAR. -She matched the MAR to the medications on hand. -She had never faxed the FL2 to the pharmacy. Interview with the SIC/Owner on 08/14/25 at	C 315			

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C 315	Continued From page 22 3:00pm revealed she expected the FL2 to match the MAR when the PCP signed the FL2. Interview with the Administrator on 08/14/25 at 3:37pm revealed that he expected the FL2 to be completed correctly, signed, and faxed to the pharmacy.	C 315			