

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL056006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/21/2025
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NAME OF PROVIDER OR SUPPLIER FRANKLIN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 186 ONE CENTER STREET FRANKLIN, NC 28734
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{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey with the Macon County Department of Social Services from 05/20/25 to 05/21/25.	{D 000}		
{D 358}	<p>10A NCAC 13F .1004(a) Medication Administration</p> <p>10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 Residents (#2) including a medication used to treat mental health disorders and two medications used to prevent seizures.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL2 dated 04/23/25 revealed: -Diagnoses included vascular dementia and epilepsy. -She was constantly disoriented.</p> <p>Review of Resident #2's current physician orders dated 04/23/25 revealed: -There was an order for quetiapine (an antipsychotic medication used to treat mental</p>	{D 358}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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{D 358}	<p>Continued From page 1</p> <p>health disorders) 200mg tablet twice daily. -There was an order for carbamazepine (used to treat epilepsy) 20mg tablet twice daily. -There was an order for phenytoin sodium (used to treat epilepsy) 100mg capsule twice daily.</p> <p>Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine 200mg tablet twice daily. -The quetiapine was scheduled for administration at 9:00am and 9:00pm. -There was documentation the quetiapine was placed "on hold" on 04/29/25 at 9:00am. -There was an entry for carbamazepine 200mg tablet twice daily. -The carbamazepine was scheduled for administration at 9:00am and 9:00pm. -There was documentation the carbamazepine was placed "on hold" on 04/28/25 at 9:00am, 04/29/25 at 9:00am, and 04/30/25 at 9:00pm. -There was an entry for phenytoin sodium 100mg capsule twice daily. -The phenytoin sodium was scheduled for administration at 9:00pm. -There was documentation the phenytoin sodium was placed "on hold" on 04/28/25 at 9:00am, 04/29/25 at 9:00am, and 04/30/25 at 9:00pm.</p> <p>Review of Resident #2's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine 200mg tablet twice daily. -The quetiapine was scheduled for administration at 9:00am and 9:00pm. -There was documentation the quetiapine was placed "on hold" on 05/01/25 at 9:00pm and 05/02/25 at 9:00am.</p>	{D 358}		

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{D 358}	<p>Continued From page 2</p> <ul style="list-style-type: none"> -There was an entry for carbamazepine 200mg tablet twice daily. -The carbamazepine was scheduled for administration at 9:00am and 9:00pm. -There was documentation the carbamazepine was placed "on hold" on 05/01/25 at 9:00am and 05/01/25 at 9:00pm. -There was an entry for phenytoin sodium 100mg capsule twice daily. -The phenytoin sodium was scheduled for administration at 9:00pm. -There was documentation the phenytoin sodium was placed "on hold" on 05/01/25 at 9:00am, 05/01/25 at 9:00pm and 05/02/25 at 9:00am. <p>Interview with a MA on 05/21/25 at 9:15am revealed:</p> <ul style="list-style-type: none"> -She did not remember why she documented on the electronic medication administration report (eMAR) report on 04/25/25 to "hold" three of Resident #2's medications. -The medications were "usually" placed on hold if the medication ran out. -An order from the Primary Care Provider (PCP) was needed to place medications on hold. -She did not find an order in the computer system for the three medications for Resident #2, but the Administrator should have a "copy" in the record. -She reordered medications through the online system that communicated with the pharmacy. -She contacted the pharmacy to ensure the refill request was received. -The medications were usually delivered the same day or the next day. -The controlled medication orders should be called in to the pharmacy from the PCP. -She usually contacted the pharmacy the same day the PCP ordered the controlled medications to ensure the order was received but was not 	{D 358}		

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{D 358}	<p>Continued From page 3</p> <p>sure if she contacted the pharmacy on 04/25/25. -She usually tried to contact the pharmacy to reorder medication 3 or 4 days before the medication ran out.</p> <p>Interview with a second MA on 05/21/25 at 9:15am revealed: -She originally let management staff know on 04/27/25 that Resident #2's quetiapine, carbamazepine, and phenytoin sodium were not available for administration. -When she came back to work on 04/29/25, she informed management staff again that Resident #2's quetiapine, carbamazepine, and phenytoin sodium were not available for administration. -She did not know why those 3 medications did not come in the weekly multi-dose pack for Resident #2. -The Hospice Registered Nurse (RN) was making a weekly visit to Resident #2 on 04/29/25 and she told her the 3 medications were not available for administration to Resident #2.</p> <p>Interview with the Memory Care Coordinator (MCC) on 05/21/25 at 8:40am revealed: -Medication aides (MA) were responsible to let her know when a resident's medication was getting low and if they were out of medication for a resident. -The MAs did not follow procedure to notify her Resident #2 was low on the quetiapine, carbamazepine, and phenytoin sodium or when the last dose was given. -She was not notified until 04/29/25 by a MA that Resident #2 had been out of her quetiapine, carbamazepine, and phenytoin sodium for several days. -She told the MA to put the quetiapine, carbamazepine and phenytoin sodium "on hold" until the medications were received from the</p>	{D 358}		

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{D 358}	<p>Continued From page 4</p> <p>pharmacy.</p> <p>Interview with the Resident Care Coordinator (RCC) on 05/21/25 at 9:05am revealed:</p> <ul style="list-style-type: none"> -When a MA discovered a medication was not available for administration, the MA was responsible for letting her know or the MCC. -The MA was responsible for calling the pharmacy to verify the medication was scheduled to be sent to the facility. -The medication Resident #2 was prescribed was packaged in a multi-dose pack from the pharmacy and was delivered weekly. -She and the MCC were responsible for verifying all the medications were in the multi-dose packs for each resident when they were received from the pharmacy. <p>Attempted telephone interview with the facility's contracted pharmacy on 05/21/25 at 9:38am was unsuccessful.</p> <p>Telephone interview with the hospice primary care provider (PCP) on 05/21/25 at 10:35am revealed:</p> <ul style="list-style-type: none"> -She had not been informed by the facility that Resident #2 went without her quetiapine, carbamazepine, and phenytoin sodium for several days. -She was in the facility most recently on 04/30/25 and reviewed and signed orders presented to her. -There was not an order to hold Resident #2's quetiapine, carbamazepine, and phenytoin sodium presented to her to sign. <p>Interview with the Administrator on 05/21/25 at 10:58am revealed:</p> <ul style="list-style-type: none"> -Most all scheduled non-narcotic medications went sent to the facility weekly in a multi-dose pack from the pharmacy. -There was lack of timely communication 	{D 358}		

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{D 358}	Continued From page 5 between the MAs and the MCC when it was discovered Resident #2 was missing 3 of her scheduled medications.	{D 358}		