

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Pitt County Department of Social Services conducted an annual and follow-up survey on November 4, 2014.	C 000		
C 078	<p>10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes.</p> <p>This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure two of two bathrooms (bathroom #1 and bathroom #2) used by residents were clean and in good repair. The findings are:</p> <p>Observation of bathroom #1 located next to kitchen entrance on 11/4/14 at 4:00 p.m. revealed:</p> <ul style="list-style-type: none"> - Brown rust stains surrounded the sink faucet. - Brown stains covered the inner sink. - Greater than 3 areas of old dried caked on toothpaste stuck inside sink. - Thick dark black and rust colored glue like substance surrounded the tile around the tub. - Baseboards around the floor and tub were covered with thick brown scum. - Build up of dirt and dust on the floor. <p>Observation of bathroom #2 located adjacent to residents rooms on 11/4/14 at 4:15 p.m. revealed:</p>	C 078		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 078	<p>Continued From page 1</p> <ul style="list-style-type: none"> - The tile around the tub was broken into greater than 10 pieces. - The handle to the shower was missing. - The toilet was constantly running water. - The baseboards were covered in thick brown dirt. <p>Interview with the Supervisor in Charge (SIC) on 11/4/14 at 4:48 p.m. revealed:</p> <ul style="list-style-type: none"> - She cleans the house every day. - The administrator fixed the tiles around bathroom #2 last week and now they are broken up again. <p>Interview with the Administrator on 11/4/14 at 6:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The SIC is supposed to clean the home every day. - "I just fixed the tile around the bathtub". - He will fix the broken tile around the tub of bathroom #2 this week. - The water constantly running in bathroom #2 toilet is an easy fix all he needs to do is "buy a ball and stopcock". - He will make sure the handle on the shower in bathroom #2 will be replaced. 	C 078		
C 243	<p>10A NCAC 13G .0901(b) Personal Care and Supervision</p> <p>10A NCAC 13G .0901 Personal Care And Supervision</p> <p>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 243	<p>Continued From page 2</p> <p>Based on observation and interview, the facility failed to provide supervision to 2 of 6 residents known to smoke inside of the facility. The findings are:</p> <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> - Two residents here smoke inside the home. - Most of the time they smoke in the bathroom. - Sometimes they smoke in their room. - "We are not supposed to smoke inside the house". - "We are supposed to smoke outside". - The Supervisor-In-Charge (SIC) tells them not to smoke in the house but the residents do it anyway. - The SIC does not come to the resident rooms or to do checks and that is why the residents smoke inside the home. <p>Another confidential resident interview revealed:</p> <ul style="list-style-type: none"> - "Cigarette ashes be on the commode and inside the toilet from where someone been smoking in the bathroom". - "Sometimes the smoke detector goes off" because residents be smoking in the house". - "I smoke outside". <p>Interview with the SIC on 11/4/14 at 5:00 p.m. revealed:</p> <ul style="list-style-type: none"> - The residents are not supposed to smoke in the house. - She tells them verbally not to smoke in the house and the residents do it anyway. - She smelled smoke in a resident room last week and the alarm activated. - She has not written any of the residents up for smoking inside the home. - She has not told the administrator the residents smoke in the home. - She will start writing the residents up if they 	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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 243	<p>Continued From page 3</p> <p>are caught smoking in the home.</p> <p>Interview with the Administrator on 11/4/14 at 6:00 p.m. revealed:</p> <ul style="list-style-type: none"> - There should be no smoking in the house. - Residents are aware of the rule of no smoking in the home. - If the residents are caught smoking inside the home they will get written up. - If the residents continue to smoke in the home after three written warnings, the administrator will proceed with discharging the residents from the home. <hr/> <p>The Plan of Protection dated 11/4/14 revealed:</p> <ul style="list-style-type: none"> - The facility will monitor for residents smoking in rooms and at the facility. - The facility will reprimand a resident if caught smoking in room by talking with him about the rules and policies. - The facility will notify the resident doctor and family member about the smoking problem. - The facility will notify the resident doctor and family member the facility cannot tolerate residents smoking in the facility any longer. - The facility will first take the residents cigarettes and ration them only when monitored by Supervisor or Aide. - If residents are caught smoking in facility after 3 warnings, the resident will be moved to another facility. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2014.</p>	C 243		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 4	C 246		
C 246	<p>10A NCAC 13G .0902(b) Health Care</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review the facility failed to notify the physician of 1 of 3 sampled residents (#1) known to have drinking problems. The findings are:</p> <p>Review of Resident #1's FL-2 dated 6/5/14 revealed: - Diagnoses of anxiety, hypothyroidism, neck cancer, and night sweats. - Medication orders for Remeron 15mg every day(Remeron is a antidepressant), Melatonin 3 mg at bedtime (Melatonin in used for sleep), Paxil 20 mg at bed time(Paxil is a antidepressant).</p> <p>According to the Resident Registry Resident #1 was admitted to the facility 1/10/14.</p> <p>Observation on 11/4/14 at 5:15 pm revealed - Resident #1 walking down the side walk towards the facility. - The resident began talking to other residents in the front yard. - The resident sat on the front porch and retrieved a can from his pocket.</p> <p>Interview with Resident #1 at 5:20pm revealed: - " I am sixty years old and I do what I want to do " - When asked, the resident stated he was drinking a margarita.</p> <p>Observation of Resident #1 on 11/4/14 at 5:35 pm</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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	<p>Continued From page 5</p> <p>revealed:</p> <ul style="list-style-type: none"> - The resident lying on the bed. - A green and silver margarita can with a black straw sitting on the edge of the night stand next to the resident's bed. <p>Interview with the Supervisor in Charge (SIC) on 11/4/14 at 5:40pm revealed:</p> <ul style="list-style-type: none"> - Alcoholic beverages are not supposed to be consumed on the premises. - Each resident is aware of house rules. - If resident's are caught they are given a written warning. - If behavior continues they are given a 30 day notice for discharge. - The SIC reports to the administrator any issues of residents not following the house rules. - The SIC notified the administrator a week ago that Resident #1 had beer in the resident's room. - The SIC did not call the physician, because the physician knew about the resident drinking problems when the resident was admitted to the facility. - Resident #1 will come in the facility and go straight to his room and get in bed. - The SIC will talk to resident in the bed and the resident will not look at the SIC. <p>Interview with Administrator on 11/4/14 at 7:10 pm revealed:</p> <ul style="list-style-type: none"> - The resident has a drinking problem. - Staff had received calls from local law enforcement and county representatives to come pick up the resident in the community because the resident had been observed pan handling and drinking while away from the facility. - This is not a new problem everyone knows the resident drinks. 	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3		STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834		
(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 6 Telephone interview with Primary care provider office nurse on 11/5/14 at 4:15pm revealed: - There is no documentation that the facility staff notified the physician that the resident had been intoxicated or consuming alcoholic beverages. - The facility staff should call the physician office if the resident is consuming alcoholic beverages. - The primary care provider was not aware the resident was consuming alcoholic beverages. - If the resident is drinking, electrolytes imbalance could occur and cause problems for the resident. - If the resident is taking medications and consuming alcoholic beverages it may cause the resident problems with drug interactions. The physician does not recommend the resident consume any alcoholic beverages.	C 246		
C 256	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure the kitchen, dining, and food storage areas were clean and protected from contamination. The findings are: Observation of the kitchen on 11/4/14 at 4:30 p.m. revealed:	C 256		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 256	<p>Continued From page 7</p> <ul style="list-style-type: none"> - Dirty pots and pans in the sink with stuck on food particles. - A sandwich of meat and cheese wrapped in clear wrap lying on the counter. - White cabinets had brown rust colored stains. - Cabinet above the stove contained a clear plastic container of used grease with old food crumbs/particles noted at the bottom - White base boards were covered with black build up dirt. - Two roaches crawled out of the kitchen cabinet above the sink and went back into the cabinet. - A roach crawled on the kitchen counter. - Roaches crawled on the kitchen floor and went underneath the refrigerator. <p>Confidential interview with a resident revealed:</p> <ul style="list-style-type: none"> - He has seen roaches for a "few" months now. - He see roaches in his bedroom and in the kitchen. - The roaches are not as bad as they used to be. - The "roach man" used to come and spray them but he has not seen him in a while. - He has not told anyone that he has been seeing roaches. - The SIC "she knows about the roaches because she makes us clean our room everyday". <p>Interview with the Supervisor in Charge (SIC) on 11/4/14 at 4:48 p. m. revealed:</p> <ul style="list-style-type: none"> - She cleans the house every day. - She uses the "old" grease to "season" her food when she cooks. - The roaches have been here for "four months". - The roaches are "not a problem". - She normally see the roaches behind the 	C 256		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 256	<p>Continued From page 8</p> <p>refrigerator and in a resident's top dresser drawer.</p> <ul style="list-style-type: none"> - She made the administrator aware of the roaches "less than a month ago". <p>Review of the sanitation home inspection report dated 8/26/14 revealed an approved score with a 10 point demerit.</p> <p>Review of invoice from exterminating company revealed:</p> <ul style="list-style-type: none"> - Exterminating company last sprayed the facility on 8/13/13. - The exterminating company sprayed the home for roaches. <p>Interview with the Administrator on 11/4/14 at 6:00 p.m. revealed:</p> <ul style="list-style-type: none"> - He does not see anything wrong with re-using old grease because he does it at his other home all the time. - He did not know there was a roach problem in the home. - He once had the home on an exterminating plan to have the roaches sprayed once per month for roaches. - He had the plan discontinued when the roach problem went away. - Now that he is aware of roaches in the home, he will have the exterminator come to the home once a month to spray the roaches. 	C 256		
C 284	<p>10A NCAC 13G .0904(e)(4) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service</p> <p>(e) Therapeutic Diets in Family Care Homes:</p> <p>(4) All therapeutic diets, including nutritional</p>	C 284		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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 284	<p>Continued From page 9</p> <p>supplements and thickened liquids, shall be served as ordered by the resident's physician.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observation, interview and record review the facility failed to served nutritional supplements and therapeutic diet (puree meats) to 1 of 1 sampled resident (#1) who had recent weight loss and swallowing problems. The findings are:</p> <p>Review of Resident #1's current FL-2 dated 6/5/14 revealed:</p> <ul style="list-style-type: none"> - Diagnoses of anxiety, hypothyroidism, neck cancer, and night sweats. - Diet order for puree meats only. - Supplement diet order for might shakes three times a day <p>According to the Resident Registry Resident #1 was admitted to the facility 1/10/14.</p> <p>Interview with Resident #1 on 11/4/14 at 5:15 pm revealed:</p> <ul style="list-style-type: none"> - The facility blender had been broke for a while(several weeks), the staff dropped it and it broke. - The resident would cut the meat as thin as possible. <p>Observation on 11/4/14 at 6:00 pm revealed:</p> <ul style="list-style-type: none"> - The Administrator brought several bags into the facility. - The SIC removed a blender from one of the bags. 	C 284		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 284	<p>Continued From page 10</p> <ul style="list-style-type: none"> - The SIC removed food from the bags brought in by the Administrator for the residents' dinner meal. - The food had been already cooked and ready to be served. <p>Observation of the dinner meal on 11/4/14 at 6:15 pm revealed:</p> <ul style="list-style-type: none"> - Resident #1's meat finely shredded along with vegetables. - The resident opened packages of ketchup and putting it on the meat. - The resident spoon fed himself. - The resident intermittently coughed during the meal. <p>Interview with Resident #1 at 5:20pm revealed:</p> <ul style="list-style-type: none"> - "I am sixty years old and I do what I want to do." - "The physician said I was not getting enough calories and wanted to have a supplement". - The resident had not had a supplement since ordered by the physician. <p>Interview with the Supervisor in Charge (SIC) on 11/4/14 at 5:30 pm revealed:</p> <ul style="list-style-type: none"> - Resident #1 had physician orders for might shakes (nutritional supplement). - Medicaid will not pay for the shakes, not sure what the facility was supposed to do. - The SIC, had informed the administrator, but did not receive an answer when explaining that medicaid would not pay. - The SIC did follow up with the administrator and the resident should have received the supplement as ordered. - The Administrator had brought food in for the resident because the SIC had forgotten to defrost 	C 284		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	----------------------------------------------------------------------------	------------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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 284	<p>Continued From page 11</p> <p>the chicken.</p> <ul style="list-style-type: none"> - The SIC stated, she had forgot to put applesauce in the blender when fixing the resident's meat. - The facility does not weight residents, Resident #1 is weighed at the physician's office. <p>Interview with Administrator on 11/4/14 at 7:10 pm revealed:</p> <ul style="list-style-type: none"> - Staff should prepare and serve food in accordance to physician orders. - The Administrator was not aware that the blender had been broken. - Staff should have follow up with me, if medicaid would not pay then the facility would have purchased the supplements. <p>Telephone interview with Primary care provider office nurse on 11/5/14 at 4:15pm revealed:</p> <ul style="list-style-type: none"> - When the resident was seen on 6/5/14 the resident had lost weight and nutritional supplements had been ordered. - Diet was changed to puree meats from an all puree diet because the resident said he has problems with meats. - The order was for puree meats because the resident cannot swallow the meat without difficulty. - The resident uses a straw to get the meats consumed and food need to be moist enough the resident could use the straw to swallow. <p>Review of Plan of Protection dated 11/4/14 revealed:</p> <ul style="list-style-type: none"> - The Administrator will provide training to staff regarding puree diets. - The Administrator will monitor staff closely to assure diets are served as ordered. - The Administrator will notify the physician that the resident had not received supplements as 	C 284		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	------------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 284	Continued From page 12 ordered. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2014.	C 284		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure appropriate care and services were provided to residents related to nutritional supplement, therapeutic diets and supervision. The findings are: 1. Based on observation, interview and record review the facility failed to served nutritional supplements and therapeutic diet (puree meats) to 1 of 1 sampled resident (#1) who had recent weight loss and swallowing problems[Refer to Tag D284, 10A NCAC 13G .0904(e)(4) (Type B Violation)]. 2. Based on observation and interview, the facility failed to provide supervision to 2 of 6 residents known to smoke inside of the facility. [C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------

(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 912	Continued From page 13 Refer to Tag D243, 10A NCAC 13G .0901(b) (Type B Violation)]	C 912		
C 934	<p>G.S. 131D-4.5B (a) ACH Infection Prevention Requirements</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on interviews, employee record reviews, the facility failed to assure 1 of 1 live in staff (A) completed the state mandated infection control course. The findings are:</p> <p>Review of Staff A's employee records revealed:</p> <ul style="list-style-type: none"> - Staff A's hire date of 9/12/1994. - Staff A job title as Supervisor in Charge. - No documentation found for completion of infection control training. 	C 934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL074045	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2014
--------------------------------------------------	---------------------------------------------------------------------	-----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER FREEMAN FAMILY CARE HOME #3	STREET ADDRESS, CITY, STATE, ZIP CODE 1408 CHESTNUT STREET GREENVILLE, NC 27834
-----------------------------------------------------------------	---------------------------------------------------------------------------------------

(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 934	<p>Continued From page 14</p> <p>Interview with Staff A on 11/4/14 at 4:00 pm revealed:</p> <ul style="list-style-type: none"> - She had not taken completed the infection control course by state. - The administrator is responsible for assuring staff get necessary training. <p>Telephone interview with the Administrator on 11/4/14 at 4:20 pm revealed:</p> <ul style="list-style-type: none"> - Staff had not completed the state infection control training. - The administrator had just became aware that staff were supposed to take the training. - Staff will complete infection control training. 	C 934		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number FCL074045	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 11/5/2014
Name of Facility FREEMAN FAMILY CARE HOME #3	Street Address, City, State, Zip Code 1408 CHESTNUT STREET GREENVILLE, NC 27834	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>C0330</u> Reg. # <u>10A NCAC 13G .1004(a)</u> LSC _____	Correction Completed 11/04/2014	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____	Date: _____	Signature of Surveyor: <i>Lisa Oakley</i>	Date: <u>11/18/14</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/12/2013	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
-----------------------------------------------	---------------------------------------------------------------------------------------------------------------------------