

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406		
(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 and complaint investigation on November 16-18, 2015	C 000		
C 237	10A NCAC 13G .0802 (b) Resident Care Plan 10A NCAC 13G .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Subchapter This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure the Care Plan was revised as needed based on assessment requirements for 1 of 3 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL2 dated 06/22/15 revealed diagnoses of psychotic disorder, personality disorder, selective autism, and social paranoia. Review of the Resident Register revealed Resident #1 was admitted to the facility on 04/10/07. Review of Resident #1's record revealed: -Resident #1 had a Resident Assessment dated 06/22/15 and a care plan signed by the physician on 06/22/15 -There were no additional care plans located in the resident's record. -The resident had not been approved for Personal Care Service reimbursement.	C 237		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Bonnie Watlington

Administrator

12/24/15

STATE FORM

MSX711

If continuation sheet 1 of 18

*Plan of Correction approved with addendum to tag 330 as discussed by phone with Bonnie Watlington, Administrator on 1/21/16 at 9:40am.
Cherry Poplins
ASCI 1/21/16*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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 237	<p>Continued From page 1</p> <p>Review of Resident #1's care plan dated 06/22/15 revealed Activities of Daily Living (ADL) performance codes as follows: -Eating- 2 (limited assistance) -Toileting -1 (supervision) -Ambulation/Locomotion - no documented performance code -Bathing- 2 (limited assistance) -Dressing - 2 (limited assistance) -Grooming- 2 (limited assistance) -Transfer - no documented performance code</p> <p>Observation of Resident #1 during the dinner meal on 11/16/15 from 4:45 pm to 5:15 pm revealed: -Staff prepared the meal and set the table for Resident #1. -Resident #1 fed himself the meal without assistance or difficulty.</p> <p>-Observation of Resident #1 on 11/17/15 at 8:25 am revealed: -Resident #1 was up and dressed neatly. -Resident #1 was ambulating independently.</p> <p>Interview with Resident #1 during the initial tour on 11/16/15 at 12:58 pm revealed: -He had resided at the facility for 8 years. -He could perform all of his ADL's, including bathing, dressing and eating -He had been to the dentist that morning and had two teeth pulled. -He performed tasks at the facility (voluntarily), including helping with yard work during the summer and light household cleaning. -He assisted a local church and a barbershop with cleaning to make extra money. -He walked to the church and barbershop and in the community.</p>	C 237		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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 237	<p>Continued From page 2</p> <p>Further interview with Resident #1 on 11/17/15 at 8:25 am revealed: -He had dressed himself without assistance this morning. -He was going out of the facility this morning to "hustle some jobs" to make him some money. -He went out of the facility without supervision.</p> <p>Interview with a Supervisor-in-Charge (SIC) on 11/17/15 at 7:50 am revealed Resident # 1 was independent with all ADL's.</p> <p>Telephone interview with an SIC on 11/17/15 at 3:20 pm revealed: -Resident #1 was "high functioning" -She sometimes assisted him on Sundays with fastening his tie and buttoning his shirt. -She did not assist him with other personal care tasks as he was independent with toileting, bathing, ambulation, and other dressing needs. -She referenced the care plans for residents to see what level of assistance they required. -She had worked at the facility since June 2014 and thought Resident #1's care needs had improved since she had been working at the facility. -She was not aware of Resident #1 assisting with yard work at the facility</p> <p>Interview with the Administrator on 11/17/15 at 1:10 pm revealed: -"He cleans a barbershop and has a key to it." -The facility had experienced recent staff turnover and the person that had been responsible for ensuring care plans were updated as needed was no longer employed with the facility. -She was now responsible for completing and updating the care plans. -She was aware the care plan for Resident #1</p>	C 237	<p>Staff will receive training 1/18/15 on completing Person Care Plans to reflect residents' person care needs accurately</p>	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BRITTON STREET GREENSBORO, NC 27406		
(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 237	Continued From page 3 reflected Resident #1 required more care than he needed. -My staff doesn't know how to do the care plans." -She did not receive Personal Care Service reimbursement for Resident #1. -She thought she had completed an updated care plan for Resident #1, but was unable to locate it.	C 237	All residents care plans were updated by their physicians and updated care plans were placed in residents' files. Administrator will continue to monitor care plans for accuracy and changes.	12/14/15
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: Based on interviews and record reviews, the facility failed to ensure referral and follow up an eye examination for 1 of 3 sampled residents (Resident #2). The findings are: Review of Resident #2's current FL2 dated 06/03/15 revealed diagnoses included mental retardation, insulin-dependant diabetes mellitus, hyperlipidemia, and eczema. Review of the Resident Register revealed Resident #2 was admitted to the facility on 06/15/10. Review of Resident #2's record revealed: -A Physician's Order Sheet signed by the physician on 10/16/15 which included an order for an eye examination. -No documentation an eye examination appointment had been arranged by the facility. -Documentation on the Resident's Care Plan	C 246	Resident #2 had an eye examination on 12/21. Doctor order form now shows the completion of this eye examination. In the future Administrator will review all medical referrals and see that necessary appointments are scheduled and kept.	12/21/15 11/18/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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 4</p> <p>completed on 6/3/15 revealed the resident's vision was adequate for daily activities.</p> <p>Review of the Licensed Health Professional (LHPS) evaluation dated 09/02/15 revealed: -Resident #2 stated his vision was okay with no recent changes. -Resident #2 saw an eye doctor yearly.</p> <p>Interview with Resident #2 on 11/18/15 at 2:05 pm revealed: -He had been a diabetic "for a long time" and was on insulin. -The facility took him to an appointment with his medical provider "around Halloween". -He had not been to an eye doctor appointment recently.</p> <p>Telephone interview on 11/17/15 at 4:10 pm with a nurse at Resident #1's primary physician's office revealed the eye examination was ordered due to Resident #2 being a diabetic.</p> <p>Interview on 11/17/15 at 9:50 am with the Administrator revealed: -The Supervisor-in-Charge (SIC) was responsible for scheduling medical appointments for residents. -The SIC was responsible for reviewing physician's order to ensure they were completed. -The facility recently had changes in SIC staff and the person that would have been responsible for making the eye doctor appointment for Resident #2 no longer worked at the facility. -The Administrator did not know that the appointment had not been scheduled. -The Administrator was currently responsible for ensuring medical appointments were scheduled. -The Administrator was responsible for training new SIC's to follow through with making medical</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER
WATLINGTON FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**1801 BRITTON STREET
GREENSBORO, NC 27406**

(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 5 appointments for residents as ordered. -She needed to review resident's records more often to ensure orders were completed.	C 246		
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 Based on observation, record review and interviews the facility failed to assure medications were administered as ordered for 1 sampled resident with physician ordered Finger Stick Blood Sugars and the administration of sliding scale insulin (Resident #2). The findings are: Review of Resident #2's current FL2 dated 06/03/15 revealed: -Diagnoses included insulin dependant diabetes mellitus, hyperlipidemia, and eczema. -An order for Finger Stick Blood Sugars (FSBS) three times daily before each meal. -Novolog sliding scale insulin (SSI) (Novolog is a fast-acting insulin used to lower high blood sugars) as needed with parameter SSI 3 times daily as follows:	C 330	Resident #2's physician faxed doctor orders to facility on 11/21/15. 11/21/15 making necessary clarifications. Resident's physician ordered Finger Stick Blood Sugar twice daily @ 8 am & 8 pm. Administrator will schedule 12/17/15 more employee training on caring for diabetics and medication and implementation of doctor orders.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER
WATLINGTON FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**1801 BRITTON STREET
GREENSBORO, NC 27406**

(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	<p>Continued From page 6</p> <ul style="list-style-type: none"> -FSBS less than 150 = 0 units. -FSBS 151-200 = 2 units. -FSBS 201-250 = 4 units. -FSBS 251-300 = 6 units. -FSBS 301-350 = 8 units. -FSBS 351-400 = 10 units. -FSBS above 400 = 15 units and call physician. <p>Review of the Licensed Health Professional (LHPS) evaluation dated 09/02/15 revealed: -FSBS were being done before meals and at bedtime, "despite most recent order on FL2 for FSBS three times a day before meals - staff made aware." -Resident #2 was non-compliant with his diet. -Staff often found empty food wrappers and plastic soda bottles hidden in his room. -Resident #2 had minimal knowledge of diabetes mellitus. -The LHPS nurse spoke with the staff about clarifying the physician order for FSBS for three times a day versus four times a day.</p> <p>There was no documentation in Resident #2's physician orders to change the FSBS testing from three times a day to four times a day.</p> <p>Review of September 2015 SSI administration record (a form developed by the facility for documentation of SSI) for Resident #2 revealed: -FSBS ranged from 50 to 373. -FSBS was scheduled four times a day at 8:00 am, 12:00 pm, 5:00 pm, and 8:00 pm. -There was no documentation of FSBS or amount of Novolog given on 09/03/15 12:00 pm, 09/04/15 8:00 am, 09/07/15 5:00 pm, 09/08/15 12:00 pm and 5:00 pm, 09/09/15 5:00 pm, 09/11/15 12:00 pm, 09/12/15 08:00 am, 09/23/15 8:00 am, 09/23/15 5:00 pm, 09/25/15 8:00 am and 5:00 pm, 09/28/15 5:00 pm, 09/29/15 5:00</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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	<p>Continued From page 7</p> <p>pm, and 09/30/15 12:00 pm.</p> <p>-On 09/02/15 at 5:00 pm, there was documentation "did not take per nurses orders".</p> <p>-There was no documentation in the record of an order to not administer the SSI on 09/02/15.</p> <p>-There was no documentation of why the scheduled SSI was not done for the other times in September 2015.</p> <p>-There were FSBS results documented at 8:00 pm with Novolog insulin administered as follows: 09/01/15, FSBS-160 (2 units), 09/02/15, FSBS-119 (0 units), 09/03/15, FSBS-172 (2 units), 09/08/15, FSBS-125 (0 units), 09/12/15, FSBS-232 (4 units), 09/13/15, FSBS-50 (0 units), 09/14/15, FSBS-118 (0 units), 09/15/15, FSBS-161 (2 units), 09/17/15, FSBS-118 (0 units), 09/19/15, FSBS-190 (2 units), 09/21/15, FSBS-113 (0 units), 09/24/15, FSBS-205 (4 units), 09/25/15, FSBS-171 (0 units), 09/26/15, FSBS-255 (6 units), 09/28/15, FSBS-215 (4 units), and 09/29/15, FSBS-231 (4 units).</p> <p>-There were no orders to do FSBS at 8:00 pm for SSI.</p> <p>-Documentation of 4 occurrences where Novolog (SSI) was administered incorrectly as ordered by the physician as follows:</p> <p>-On 09/09/15, at 12:00 pm FSBS 177, received 0 units and should have received 2 units.</p> <p>-On 09/10/15, at 12:00 pm FSBS 187, received 0 units and should have received 2 units.</p> <p>-On 09/16/15, at 5:00 pm FSBS 194, received 4 units and should have received 2 units.</p> <p>-On 09/17/15, at 5:00 pm FSBS 359, received 8 units and should have received 10 units.</p> <p>Review of October 2015 SSI administration record for Resident #2 revealed:</p> <p>-FSBS ranged from 57 to 348.</p> <p>-FSBS was scheduled four times a day at 8:00 am, 12:00 pm, 5:00 pm, and 8:00 pm from</p>	C 330 11/18/15 SF	Addendum: Administrator will monitor administration of Insulin for accuracy/changes.	

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER: **WATLINGTON FAMILY CARE HOME**
STREET ADDRESS, CITY, STATE, ZIP CODE: **1801 BRITTON STREET GREENSBORO, NC 27406**

(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	<p>Continued From page 8</p> <p>10/01/15 to 10/29/15.</p> <p>-There was no documentation of FSBS or amount of Novolog (SSI) given on 10/01/15 5:00 pm, 10/02/15 5:00 pm, 10/13/15 5:00 pm, and 10/29/15 12:00 pm.</p> <p>-There were FSBS results documented at 8:00 pm with Novolog (SSI) administered as follows: 10/01/15, FSBS-57 (0 units), 10/02/15, FSBS-160 (2 units), 10/03/15, FSBS-122 (0 units), 10/04/15, FSBS-177 (2 units), 10/12/15, FSBS-143 (0 units), 10/14/15, FSBS-127 (0 units), 10/15/15, FSBS-228 (4 units), 10/16/15, FSBS-169 (2 units), 10/18/15, FSBS-247 (4 units), 10/19/15, FSBS-150 (no documentation), 10/21/15, FSBS-200 (2 units), 10/24/15, FSBS-160 (2 units), 10/28/15, FSBS-101 (no documentation), 10/29/15, FSBS-105 (no documentation), and 10/30/15, FSBS-138 (no documentation).</p> <p>-There were no orders to do FSBS at 8:00 pm for SSI.</p> <p>-Documentation of 1 occurrence where Novolog (SSI) was administered incorrectly as ordered by the physician as follows:</p> <p>-On 10/28/15, at 8:00 pm FSBS 189, received 1 unit and should have received 2 units.</p> <p>-Beginning on 10/29/15, a new Blood Sugar Documentation form was implemented by staff after meeting with the physician to discuss Resident #1's blood sugars and SSI administration.</p> <p>-The new form had a handwritten note "new blood sugar form from the resident's physician" at the top of the form.</p> <p>-There were seven columns on the form labeled as follows:</p> <p>(1) FSBS (2) 2 hours after breakfast (with handwritten 10 am), (3) before lunch (with handwritten 30 minutes before),</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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	<p>Continued From page 9</p> <p>(4) 2 hours after lunch (with handwritten 2 pm), (5) before supper (with handwritten 30 minutes before), (6) 2 hours after supper (7) bedtime.</p> <p>-There was no column on the new form to indicate how many units of insulin were administered.</p> <p>There was no documentation in Resident #2's physician orders to change the FSBS testing from three times a day to six times a day.</p> <p>Review of November 2015 FSBS and SSI log for Resident #2 revealed: -FSBS ranged from 74 to 334. -There were no documented FSBS's before breakfast, as ordered. -Blood sugars were documented from 4 to 6 times a day as follows: -Two hours after breakfast 13 of 16 days documentation of FSBS with resident refusing three times (There was no order for a FSBS to be done at this time). -Thirty minutes before lunch 15 of 16 days, as ordered, with no documentation of FSBS on 11/05/15. -On 11/15/15 at 12:00 pm FSBS 214, no documentation of units given and should have received 2 units. -Two hours after lunch 11 of 15 days documentation the FSBS were done (There was no order for a FSBS to be done at this time). -Thirty minutes before supper 16 of 16 days FSBS were completed as ordered. -Two hours after supper 15 of 16 days FSBS were completed (There was no order for a FSBS to be done at this time). -Bedtime 13 of 15 days FSBS were completed (There was no order for a FSBS to be done at</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER
WATLINGTON FAMILY CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**1801 BRITTON STREET
GREENSBORO, NC 27406**

(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	<p>Continued From page 10</p> <p>this time)</p> <p>-No documentation on the FSBS log of Novolog insulin administered.</p> <p>Review of November Medication Administration Record (MAR) for Resident #2 revealed:</p> <p>-Documentation of administration of Novolog insulin was documented on the back of the MAR.</p> <p>-There was no documentation that FSBS were completed before breakfast, as ordered.</p> <p>-Two hours after breakfast, Novolog insulin was administered four times (11/02/15, 11/04/15, 11/06/15, and 11/15/15) based on the sliding scale parameters, but a FSBS at this time was not ordered.</p> <p>-Two hours after lunch, Novolog insulin was administered three times (11/01/15, 11/02/15, and 11/09/15) based on the sliding scale parameters, but a FSBS at this time was not ordered.</p> <p>-Two hours after supper, Novolog insulin was administered five times (11/01/15, 11/02/15, 11/03/15, 11/14/15, and 11/16/15) based on the sliding scale parameter, but a FSBS at this time was not ordered.</p> <p>-At bedtime, Novolog insulin was administered once, on 11/03/15, based on the sliding scale parameters, but a FSBS at this time was not ordered.</p> <p>Review of Resident #2's record revealed a physician's order dated 11/17/15 to check blood sugar twice a day (Fasting at 8 am and Non-fasting at 8 pm).</p> <p>Interview with Resident #2 on 11/18/15 at 2:05 pm revealed:</p> <p>-He had been a diabetic "for a long time".</p> <p>-The Medication Aides (MA) administer his insulin.</p> <p>-The MA's did "finger sticks" at breakfast, lunch,</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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	<p>Continued From page 11</p> <p>and dinner.</p> <p>-The doctor changed it one time from three times a day to 4 times a day.</p> <p>-He saw his physician "near Halloween" and the doctor changed his medicines because he said 'I take too much'.</p> <p>-He did not know what medicines were changed by the physician.</p> <p>-It did not bother him to have the finger sticks to check his blood sugars.</p> <p>-He denied having problems with his skin on his fingers where blood was drawn for FSBS.</p> <p>Observation on 11/18/15 at 2:10 pm of Resident #2's fingertips and pads of fingers on both hands revealed no bruising, swelling, or skin irritation.</p> <p>Telephone interview on 11/17/15 at 4:10 pm with a nurse at Resident #2's physician office revealed:</p> <p>-The facility staff had informed the physician previously that they were doing FSBS three to four times a day.</p> <p>-The physician told the staff that they were not to do FSBS more than the order on the FL-2 which was three times a day.</p> <p>-The physician's office provided the facility with a form on 10/29/15 that they could use to record FSBS's.</p> <p>-The form was to be used for documentation purposes only and was not a physician's order.</p> <p>-The order for the FSBS had not changed since the order written on the FL-2 on 06/03/15.</p> <p>-An employee of the facility called the physician's office on 11/09/15 to inform the doctor that the facility was doing FSBS six times a day and asked "if they were supposed to be doing them this often."</p> <p>-The physician's office informed the staff person they were to only be done three times a day as</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406		
(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 12 ordered. -The physician wrote a new order today for Resident #2 to have blood sugars checked twice a day (Fasting 8.00 am and Non-fasting 8.00 pm). Review of Resident #2's record on 11/18/15 revealed a copy of a physician's order signed 11/17/15 for blood sugars to be checked twice a day (Fasting 8.00 am and Non-fasting 8.00 pm). Telephone interview with the LHPS nurse on 11/18/15 at 12:30 pm revealed: -She did the quarterly LHPS reviews for the facility. -Resident #2 was on sliding scale insulin due to the fluctuating blood sugars. -She informed the Co-Administrator, after her review of Resident #2's record on 09/02/15, that the facility was to only do FSBS three times a day as ordered on the FL2 form. -There had been an order previously for FSBS to be done four times a day, but this was changed when the new FL2 was completed on 06/03/15. -She was not aware that the facility had recently been checking Resident #2's FSBS four to six times daily. Interview on 11/17/15 at 8:00 am with a Supervisor-in-Charge revealed: -He had been employed at the facility since June 2015. -He usually worked second and third shifts. -He was responsible for doing FSBS for Resident #3 and administering SSI as ordered by the physician. -He demonstrated how to determine from the sliding scale as to how much insulin was to be administered based on the blood sugar. -FSBS for Resident #2 were done two hours after breakfast, 30 minutes before lunch, 2 hours after	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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	<p>Continued From page 13</p> <p>lunch, 30 minutes before dinner, and 2 hours after dinner, and at bedtime.</p> <ul style="list-style-type: none"> -He referenced the SSI documentation log provided to the facility on 10/29/15 by the physician's office. -He thought the FSBS's were to be done six times a day according to the form. -He had received medication training, including how to do FSBS and sliding scale insulin, from the LHPS nurse before he starting administering medications. <p>Interview with the Co-Administrator on 11/17/15 at 3:40 pm revealed:</p> <ul style="list-style-type: none"> -He met with the physician to discuss orders for FSBS for Resident #2 in October 2015. -He and staff thought when the physician's office gave them the new form on 10/29/15, they were to change the frequency of the FSBS's. -The facility had an SIC who was responsible for ensuring physician's orders were implemented correctly. -The SIC told him after receiving the new form from the physician they were to be doing the FSBS's "according to the new form". -He did not realize there was not a new order from the physician to change the frequency of the FSBS. -He thought the SIC had clarified with the physician how often the FSBS's were to be done. -The SIC was no longer employed at the facility. -He received a new physician's order on 11/17/15 for Resident #2 for blood sugars to be checked twice a day (Fasting 8:00 am and Non-fasting 8:00 pm). -He was concerned this may not be often enough because Resident #2's blood sugars are unstable. <p>Attempted phone interview on 11/18/15 at with</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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	<p>Continued From page 14</p> <p>the former SIC was unsuccessful.</p> <p>Interview with the Administrator on 11/17/15 at 12:30 pm revealed:</p> <ul style="list-style-type: none"> -She was aware Resident #2 was on sliding scale insulin. -She was responsible for ensuring the facility provided diabetes education for Medication Aides prior to them administering insulin or doing FSBS. -The facility's LHPS nurse or the pharmacy staff provided diabetes education for staff. -The facility had experienced recent staff turnover of SICs. -The Co-Administrator and the SICs were more involved in the medical needs of the residents. -The SICs were responsible for "managing medications". -She was not aware a staff person had contacted the physician's office regarding how often FSBS were to do done. -She was not aware the facility was doing FSBS for Resident #2 four to six times a day and the order was only for three times a day. <p>A Plan of Protection provided by the facility included:</p> <ul style="list-style-type: none"> -In the future, Administrators will call doctor for clarification and receipt of doctor's orders before implementing care or treatment of the resident. -All staff will be retrained regarding implementation of physician orders, including sliding scale. -Quality team will review the process for implementation of physician orders. <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 2, 2015.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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 15	C 912		
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 residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations regarding the implementation of physician's orders related to fasting blood sugars and sliding scale insulin administration. The findings are: Based on observation, record review and interviews, the facility failed to assure medications were administered as ordered for 1 sampled resident with physician ordered Finger Stick Blood Sugars and the administration of sliding scale insulin (Resident #2). [Refer to Tag C330, 10A NCAC 13F.1004 (a). (Type B Violation)]	C 912		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes.	C992		

Administrator will monitor 11/18/15 residents' care and services more closely to assure that they all are in compliance regarding doctor orders.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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
C992	<p>Continued From page 16</p> <p>(a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure an examination and screening for the presence of controlled substances was performed for 1 of 3 sampled staff (Staff C) hired after 10/01/13 before the employee began working at the facility.</p>	C992	<p>All staff are now drug tested.</p> <p>Administrator will require drug testing before hire in future</p>	11/18/15

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041026	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1801 BRITTON STREET GREENSBORO, NC 27406
---	--

(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
C992	<p>Continued From page 17</p> <p>The findings are:</p> <p>Review of Staff C's personnel record revealed:</p> <ul style="list-style-type: none"> -Hire date of 11/16/15. -Staff C was hired as a Habilitation Technician and a Home Supervisor. -There was no documentation of completion of a controlled substance examination and screening prior to the Staff C beginning work at the facility on 11/16/15. <p>Observation on 11/16/15 revealed:</p> <ul style="list-style-type: none"> -At 1:15 pm, Staff C was peeling potatoes in the kitchen for the evening meal. -The Administrator provided verbal prompts as to the location of kitchen utensils. -At 1:50 pm, the Administrator reviewed the menu for supper and posted therapeutic diet menu and resident diet list with Staff C. -At 4:00 pm, Staff C was preparing vegetables for the evening meal. -At 4:45, Staff C prepared dinner plates, including therapeutic diets, for residents with the prompting of the Administrator. <p>Interview on 11/16/15 with Staff C at 4:30 pm revealed:</p> <ul style="list-style-type: none"> -This was her first day working at the facility. -She had been cooking "since I was 12". -She was receiving training from the Administrator. <p>Interview on 11/16/15 at 1:00 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -Staff C was "new and is just shadowing". -She "would be hired after she meets all of the requirements to give medicines and work with the residents". -"She can't work with the residents yet, so she is cooking." 	C992		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL041025	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WATLINGTON FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BRITTON STREET GREENSBORO, NC 27406
---	--

(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
C992	<p>Continued From page 18</p> <ul style="list-style-type: none"> -Staff C had experience working at other facilities. -Staff C had signed a permission form last week for a drug screen to be done, but the Administrator had not ensured it was completed prior to 11/16/15 "because she is just shadowing and cannot give meds yet!" <p>Further interview with the Administrator on 11/17/15 at 3:45 pm revealed:</p> <ul style="list-style-type: none"> -Staff C was being paid for the work that she was performing at the facility. <p>Further interview with Staff C on 11/17/15 at 11:00 am revealed:</p> <ul style="list-style-type: none"> -She had not had a drug screen completed prior to beginning work at the facility on 11/16/15. -She would obtain a drug screen immediately as requested by the Administrator. <p>Observation on 11/17/15 at 1:05 pm revealed Staff C returned to the facility and provided a sealed envelope to the Administrator</p>	C992		