

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL057004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2016
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NAME OF PROVIDER OR SUPPLIER MINTZ FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 192 MATO ROAD MARSHALL, NC 28753
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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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey onsite May 4, and May 5, 2016 with a telephone exit on May 09, 2016.	C 000		
C 033	<p>10A NCAC 13G .0302 (m) Design And Construction</p> <p>10A NCAC 13G .0302 Design And Construction</p> <p>(m) The building shall meet sanitation requirements as determined by the North Carolina Department of Environment and Natural Resources; Division of Environmental Health.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to meet sanitation requirements as determined by the Division of Environmental Health as evidenced by rodent droppings throughout the food pantry.</p> <p>The findings are:</p> <p>Observation of the food pantry on 05/04/16 at 9:05am revealed:</p> <ul style="list-style-type: none"> - Food pantry was beside the kitchen and the back door. - Each of the four shelves in the pantry had rodent droppings on them. - White container sitting on the floor with a jar of salsa and plastic bottle of syrup in the white container had rodent droppings in the white container. - There was an opening to the right under the last shelf in the pantry wall where an opening the size of a baseball exposed the ground underneath the 	C 033		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 033	<p>Continued From page 1</p> <p>home.</p> <p>A review of the facility's sanitation report dated 04/29/16 revealed the facility received 12 demerit points. Review of the classification status revealed the facility was approved when a facility receives 20 or less demerits, and no 6 point demerits.</p> <p>The facility received 2 demerit points in the category of Food Supplies and Protection. 4 demerit points in in the category of Vermin Control Premises.</p> <p>Interview on 05/04/16 at 9:05am with the Supervisor-In-Charge (SIC) revealed: - He had spoken with the Administrator about the hole in the pantry where the plumbing entered the pantry and the rodent concerns on several occasions but could not provide specific times. - There had been no one in the home to provide pest control services in the 7 years he had been SIC in the home.</p> <p>Interview on 05/04/16 at 11:30am with the facility Social Worker revealed: - She was unaware of any contract with pest control for house #4. - She would check with the Administrator and make sure pest control came out to assist with the rodent problem.</p> <p>Random interviews with residents residing in the facility during the survey conducted on 05/04/16 and 05/05/16 revealed no complaints.</p>	C 033		
C 034	10A NCAC 13G .0302(n) Design and Construction	C 034		

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C 034	<p>Continued From page 2</p> <p>10A NCAC 13G .0302 Design and Construction (n) The home shall have current sanitation and fire and building safety inspection reports which shall be maintained in the home and available for review.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to have a current fire and building inspection maintained in the home.</p> <p>The findings are:</p> <p>Interview on 05/04/16 at 8:25am with the SIC (Supervisor In Charge) revealed the Fire and building inspection report was not in the building and he would call the Social Worker and have it brought from the office for review.</p> <p>Interview on 05/04/16 at 11:30am with the facility Social Worker revealed: - She did not have a current Fire and Building inspection for building #4. - "I just realized it was overdue when I got it out for you." - "They have a new fire marshall now and I don't even know his name." - The facility is responsible for calling the fire marshall.</p> <p>Review of the "Adult Day Care & Child Care Fire Inspection Report" dated 04/21/15 provided by the facility Social Worker revealed the fire safety conditions in this facility were "satisfactory, approved for day and night care."</p>	C 034		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings	C 074		

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C 074	<p>Continued From page 3</p> <p>10A NCAC 13G .0315 Housekeeping And Furnishings (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; 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 walls and floor coverings were clean and in good repair in 1 of 2 common bathrooms used by the residents.</p> <p>The findings are:</p> <p>Observation on 5/04/15 at 8:39am of the common shower/bathroom revealed: -A 7 in. wide by 3 in. long section of floor tile missing between the commode and shower floor area. -The floor tiles surrounding the base of the commode were stained yellowish brown. -The shower wall tiles were stained yellowish brown and black. - The shower tiles on the bottom left side of the shower were broken -The tiles located in the front left corner were damaged and on the front and side of the shower tiles in the bottom of the shower were black. -There was had damaged tiles between the toilet and the shower.</p> <p>Observation on 5/04/15 at 8:40am of the common tub/bathroom revealed: -The bathtub area was stained yellowish brown. -The caulking around the edge of the bathtub wall was stained brown.</p>	C 074		

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C 074	<p>Continued From page 4</p> <p>Interviews with six residents at various times on 5/04/16 and 5/05/16 revealed: -None of the residents had any complaints about the condition of the floors or walls in the bathroom of the facility. -The SIC was responsible for housekeeping in the facility.</p> <p>Interview with the SIC on 5/04/16 at 8:40am revealed: -The floors in the home had not been buffed in over one year since the last survey. -He would be able to clean the floors and shower walls. - He would talk with the Administrator to repair the missing and broke floor tiles and loose bathroom tiles in the facility.</p> <p>A review of the facility's local Health and Sanitation report dated 04/29/16 revealed: -The facility received a total score of 12 demerit points. -2 demerits were taken off for floors not clean or in good repair. -1 demerit was taken off for walls not clean or in good repair. -4 demerits were taken off for vermin control of the premises, screen missing from storm door on the back of facility.</p>	C 074		
C 294	<p>10A NCAC 13G .0905(f) Activities Program</p> <p>10A NCAC 13G .0905 Activities Program (f) Each resident shall have the opportunity to participate in at least one outing every other month. Residents interested in being involved in the community more frequently shall be encouraged to do so.</p>	C 294		

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C 294	<p>Continued From page 5</p> <p>This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure that each resident has the opportunity to participate in at least one outing every other month for 6 of 6 sampled residents (#1, #2, #3, #4, #5, and #6).</p> <p>The findings are:</p> <p>On 05/04/16 and 05/05/16, random interviews with the residents in the family care home revealed: "We never go anywhere." "(Staff B's name) will take us to our doctors appointments in her car but we don't have a way to go to anywhere else." Two residents were picked up by their Pastor and taken to church on Sunday and another resident walked to church. Some of the residents would walk to the local store. "I would like to go on an outing, we never go anywhere." -"Some of the residents play cards or the board games, I have a computer game I play."</p> <p>There was no activity calendar posted in the house for May 2016 on 05/04/16 and 05/05/16. Staff B did provide a daily list of scheduled activities from 05/06/16 through 05/31/16 on 05/10/16 at 6:47am that Staff B had developed prior to the exit of the survey. Activities for 14 hours a week included: handi-helpers, church, nature walk, cards, board games, netflix movie night.</p> <p>Observation of the activity cabinet in the living room on 05/04/16 at 8:38am revealed: coloring books and crayons, cards and board games.</p>	C 294		

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C 294	Continued From page 6 Interview with SIC on 08/04/16 at 8:45am revealed: - The white van in driveway was his personal van. -"It has not been working for sometime but there is someone coming over the weekend to run a diagnostic on it." -The facility does not provide residents with any kind of transportation to take residents on outings. -"When the van is running I take the residents out on outings in my van."	C 294		
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, interviews and record reviews the facility failed to administer medications as ordered by the physician for 3 of 4 residents (Residents #2, #3, #4). The findings are: A. Review of Resident #2's FL2 dated 09/22/15 revealed: -Diagnoses included fibromyalgia, anxiety and	C 330		

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C 330	<p>Continued From page 7</p> <p>psychosis.</p> <p>-Order for Topamax 50mg a day (an anti-seizure medications sometimes used to treat nerve pain).</p> <p>A review of Resident #2's record revealed a physician's order dated 2/23/16 revealed an order for Topamax 50mg 2 tablets twice a day to be changed to Topamax 50mg 1 tablet every morning and 2 tablets at bedtime.</p> <p>Review of Resident #2's Medication Administration Record (MAR) for February 2016 revealed topamax 50 mg was scheduled for administration twice daily.</p> <p>Review of Resident #2's MAR for April 2016 revealed an entry for topamax dated 02/23/16 was not transcribed to the MAR.</p> <p>Observations of Resident #2's medications on 05/05/16 at 2:00pm revealed Topamax 50mg 1 tablet every morning and 2 tablets at bedtime was available for administration.</p> <p>Telephone interview with the pharmacy staff on 05/09/16 at 11:00am revealed:</p> <ul style="list-style-type: none"> - The prescription for the change to Topamax 50mg 1 tablet every morning and 2 tablets at bedtime was received on 2/29/16 and the medication was received at the facility on 03/01/16. - "The facility should have handwritten the change on the MAR as they would have already had the MAR's for March and the computer generated MAR would have come out in April." <p>Interview with Resident #2 on 05/05/16 at 10:30am revealed:</p> <ul style="list-style-type: none"> - She was not sure if she had been getting the right dosage for her Topamax in February and 	C 330		

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C 330	<p>Continued From page 8</p> <p>March.</p> <ul style="list-style-type: none"> - "Nobody told me about it if I didn't get it like I was supposed to." <p>Refer to interview on 05/05/16 at 3:50pm with the Supervisor in Charge (SIC).</p> <p>Refer to the interview on 05/06/16 at 3:50pm with the backup SIC for the facility.</p> <p>Refer to phone interview on 05/09/16 at 12:50pm with the mental health Nurse Practioner.</p> <p>Refer to interview on 05/09/16 at 3:01pm with the facility Social Worker.</p> <p>B. Review of Resident #3's FL2 dated 02/20/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included paranoid schizophrenia, traumatic brain injury and seizure disorder. -An order for Haloperidol (Haldol) 10 mg 3 tabs by mouth at bedtime. (Used to treat certain types of mental disorders.) <p>A review of Resident #3's record revealed a physician's order dated 03/28/16 revealed an order for Haldol 10mg 1 tablet by mouth every morning and Haldol 2 tablets by mouth every night for medication reduction.</p> <p>Review of Resident #3's Medication Administration Record for March and April 2016 revealed:</p> <ul style="list-style-type: none"> -No handwritten or documented changes to MAR with physician order change in Haldol. - The MAR was initialed as administered Haldol 10mg 3 tablets by mouth at bedtime from March 28 through April 30, 2016 to Resident #3. - The 	C 330		

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C 330	<p>Continued From page 9</p> <p>Review of Resident #3's Medication Administration Record(MAR) for May 2016 revealed an order change on a computer generated MAR for Haldol on 3/28/16 for Haldol 10mg 1 tablet by mouth every morning and Haldol 2 tablets by mouth every night.</p> <p>Observations of Resident #3's medications from the pharmacy on 05/05/16 at 2:15pm revealed: - Haldol 10mg 1 tablet by mouth every morning available for administration. - Haldol 2 tablets by mouth every night available for administration.</p> <p>Refer to interview on 05/05/16 at 3:50pm with the Supervisor in Charge (SIC).</p> <p>Refer to the interview on 05/06/16 at 3:50pm with the backup SIC for the facility.</p> <p>Telephone interview with the pharmacy staff on 05/09/16 at 11:00am revealed: - The prescription for the change to Haldol 10mg 1 tablet every morning and 2 tablets at bedtime was received on 03/28/16 and the medication was received at the facility on 03/29/16. - "The facility should have handwritten the change on the MAR as they would have already had the MAR's for April and the computer generated MAR would have come out in May."</p> <p>Refer to phone interview on 05/09/16 at 12:50pm with the mental health Nurse Practioner.</p> <p>Refer to the interview by phone on 05/09/16 at 3:01pm with the facility Social Worker.</p> <p>C. Review of Resident #4's FL2 dated 02/15/16 revealed: -Diagnoses included mental retardation and</p>	C 330		

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C 330	<p>Continued From page 10</p> <p>chronic schizophrenia. -An order for Risperdal 3.0 mg 2 tabs by mouth at bedtime. (Used to treat schizophrenia.)</p> <p>A review of Resident #4's physician's order dated 04/12/16 revealed an order change of Risperdal 4 mg by mouth at bedtime for 2 weeks, then Risperdal 1.5mg for 2 weeks at bedtime then Risperdal 1mg at bedtime.</p> <p>Review of Resident #4's Medication Administration Record for April 2016 revealed: -No documented changes to MAR with physician order change in Risperdal. - The MAR was initialed as administered Risperdal 3.0 mg 2 tablets by mouth at bedtime from April 1 through April 30, 2016 to Resident #4. -The 04/12/16 order was not transcribed to the MAR.</p> <p>Review of Resident #4's Medication Administration Record (MAR) for May revealed an order change on a computer generated MAR for Risperdal 0.5mg 2 tablets at bedtime and Risperdal 2 mg 2 tablets at bedtime.</p> <p>Observations of Resident #4's medications from the pharmacy on 05/05/16 at 2:25pm revealed: - Risperdal 0.5mg 2 tablets at bedtime for administration. - Risperdal 2 mg 2 tablets at bedtime for administration.</p> <p>Refer to interview on 05/05/16 at 3:50pm with the Supervisor in Charge (SIC).</p> <p>Refer to the interview on 05/06/16 at 3:50pm with the backup SIC for the facility.</p>	C 330		

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C 330	<p>Continued From page 11</p> <p>Telephone interview with the pharmacy staff on 05/09/16 at 11:00am revealed:</p> <ul style="list-style-type: none"> - The 04/12/16 order for the Risperdal change was recieved on 04/13/16 and the medications were available for dispensing on 04/15/16. - "The facility should have handwritten the change on the MAR as they would have already had the MAR's for April and the computer generated MAR would have come out in May." <p>-Interview by phone on 05/09/16 at 12:50pm with the mental health nurse Practioner revealed:</p> <ul style="list-style-type: none"> - "The medication reduction should have changed immediately. That's a problem." - She was unaware the orders were not being followed. - "I can't really say it was detrimental to the residents." - "Not really aware of any changes in behavior as he had been on the original dose for sometime." - "The facility needs to look at getting orders and order changes done promptly and correctly." - "They really need to be more careful." <p>Refer to the interview by phone on 05/09/16 at 3:01pm with the facility Social Worker.</p> <p>_____ Interview on 05/05/16 at 3:50pm with the Supervisor in Charge (SIC) revealed:</p> <ul style="list-style-type: none"> -He was responsible for faxing refill requests to the pharmacy "4-5 days" before a resident ran out of medication. -Medication refill requests faxed before 2:00pm normally would be at the facility that night or the next day and medications refill requests faxed after 2:00pm would be at the facility in 2 days. - "We change the MAR when the medication is actually in the building." - "Its my fault, I was supposed to check the meds 	C 330		

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C 330	<p>Continued From page 12</p> <p>against the MARS and I just put them in the cabinet without checking them." He put the new medication in the overflow meds when they came in and continued to give Resident #2, #3 and #4 the same dose of medications they had prior to the Physician order change.</p> <p>Interview on 05/06/16 at 3:50pm with the backup SIC for the facility revealed: -She was responsible for scheduling, transporting and communicating physician order changes to the facility SIC when she returned the resident to the facility after their appointments. - She could not say she had told the SIC about the medication changes.</p> <p>Interview by phone on 05/09/16 at 12:50pm with the mental health nurse Practioner revealed: - "I can't really say it was detrimental to the residents." - She was unaware the orders were not being followed. - "The facility needs to look at getting orders and order changes done promptly and correctly." - "They really need to be more careful."</p> <p>Interview by phone on 05/09/16 at 3:01pm with the facility Social Worker revealed she could not offer an explanation as to why Residents did not receive medications as ordered but agreed that the facility's system to keep up with medication changes needed to be addressed.</p> <p>The facility provided a Plan of Protection on 05/05/16 that included: - Checking MAR's against medications. -If mistakes are found correct and notify residents physician and supervisor. - Review MAR's, medications and physician's</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL057004	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/09/2016
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NAME OF PROVIDER OR SUPPLIER MINTZ FAMILY CARE HOME #4	STREET ADDRESS, CITY, STATE, ZIP CODE 192 MATO ROAD MARSHALL, NC 28753
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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 330	Continued From page 13 orders on a weekly basis for 1 month and then check monthly. -Ask Pharmacy nurse to check MAR's against pharmacy orders every 3 months. -A plan of correction date was given of June 25, 2016.	C 330		
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 review the facility failed to assure residents received care and services which are adequate, appropriate, an in compliance with relevant federal and state laws and rules and regulations related to medication administration for 3 of 4 residents. (Residents #2, #3 and #4). The findings are: Based on record observation, record review, and interviews the facility failed to administer medications as ordered for 3 of 4 residents (Residents #2, #3 and #4) regarding Topmax, Haldol, and Risperdal. [Refer to Tag C330, 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].	C 912		