

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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	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 observations and interviews, the facility failed to maintain a clean environment free of clutter and hazards in the dining room, bathrooms, and kitchen.</p> <p>The finding are:</p> <p>Observations during the entrance and initial tour of the facility on 06/08/2016 from 8:30am to 9:30am revealed:</p> <ul style="list-style-type: none"> -There were three cardboard boxes stacked against the wall entering into the kitchen and located next to a file cabinet with the top cover of a box turned upside down and containing loose papers. -There were four cardboard boxes sitting on the floor in front of a chest freezer in the dining room. -There was a folded wheelchair next to the chest freezer in the dining room. -There was a copier on top of the cabinet in the 	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: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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> <p>dining room with loose papers stacked on top of the copier.</p> <ul style="list-style-type: none"> -There was a folding table located in the corner entering into the dining room with four cardboard boxes stacked under the table, and loose papers and an electric cooking pan on top of the table. -There was a plastic bag with papers sitting on the floor beside a chair located next to the folding table in the dining room. -There was a heavy accumulation of dust on the wall vent in the hallway exiting the dining room. A sign posted over the vent read "CLEAN and check every 2 weeks". -There was soap scum on the wall of the tub/shower combo in the common resident bathroom. -There was a heavy accumulation of dust on top of the window curtain. -There were dust particles along the wall to the left of the window curtain. -There was a blackish grey bug crawling on the wall beside the toilet. -There were eight small holes in the wall above the toilet. -There was a brownish colored liquidity substance with food particles in the crevices of the bottom of an unlined trashcan sitting on the floor next to a table in the kitchen. There were brownish stains along the sides of the trashcan. <p>Confidential interviews with residents revealed:</p> <ul style="list-style-type: none"> -The residents were responsible for cleaning their rooms, the resident bathroom, and the kitchen and dining room areas. -The residents had no complaints about the cleanliness and clutter in the facility. -The residents cleaned the bathroom every day. -The residents cleaned the kitchen and dining room area every day. 	C 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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 2</p> <p>Interview with the Administrator on 06/08/2016 at 12:10pm revealed:</p> <ul style="list-style-type: none"> -The Administrator, staff and residents tried to clean every day. -The Administrator performed monthly cleaning which consisted of cleaning the curtains, blinds, scrubbing floors, dusting light fixtures, and checking the light bulbs. -The daily cleaning consisted of sweeping in the facility, mopping the floors, cleaning the oven and top of the stove, cleaning the sink in the kitchen, cleaning under the sink, and wiping the kitchen cabinet doors and the refrigerator door. -The cleaning of the bathroom was done as needed by the Administrator. -The Administrator checked behind the residents for thorough cleaning of the shower, sink, and mirrors. -The Administrator had not been in the resident bathroom in the last "couple of days". -The Administrator thought she had last checked the resident bathroom on 05/24/2016. -The Administrator tried to clean the tub/shower walls every two weeks. -If the Administrator tried to clean the shower every week it would be too much pressure on her. -Specific resident chores included cleaning in the bathroom daily. -The wall fixtures over the commode in the resident bathroom came down leaving holes in the wall which needed to be filled with putty. -The kitchen trashcan was cleaned out as needed and "right now it needs to be cleaned". -The Administrator had noticed the kitchen trashcan needed to be cleaned on 06/07/2016 but had not been able to do it. -The Administrator needed to purchase trash bags liners for the trashcan. -Resident threw food in the trash can even if there were no trash bags in the trashcan. 	C 078		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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	Continued From page 3 -The Administrator had not had time to remove the boxes in the dining room. -Some of the boxes in the dining room contained shoes and clothes of the Administrator. -Some of the boxes in the dining room contained a supply of incontinent briefs that the Administrator planned to store under the folded table. -The wheelchair had been in the corner of the dining room for a couple months. -The Administrator thought it "was back in mid-March" when hall vent was last dusted and she had placed the sign over the vent to remind herself to dust the vent. -The Administrator would clean the facility when she was finished with paperwork.	C 078		
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure accurate reconciliation of controlled substances, Clonazepam and Lorazepam, for 2 of 2 residents (Residents #1 and #2) sampled. The findings are: 1. Review of Resident #1's current FL-2 dated 03/04/16 revealed:	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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 367	<p>Continued From page 4</p> <ul style="list-style-type: none"> - Diagnoses included schizophrenia, allergic rhinitis, hypertension, and prostate cancer. -There was a physician's order for Clonazepam 0.5 mg tablet ½ three times a day (Clonazepam is used to treat seizures, panic disorders and anxiety). <p>Review of the April 2016, May 2016, and June 2016 Medication Administration Records (MARs) revealed:</p> <ul style="list-style-type: none"> -Clonazepam 0.5mg take ½ tablet by mouth three times daily as directed was printed to the MARs. -The Clonazepam was scheduled for administration at 8am, 4pm, and 8pm daily. -There was documentation of administration for the Clonazepam daily at 8am, 4pm, and 8pm from 04/01/2016 at 8am through 06/07/2016 at 8am. <p>Review of the controlled substance log for Clonazepam 0.5mg tablets for Resident #1 revealed a pharmacy label on the controlled drug record indicated 45 tablets of Clonazepam 0.5mg tablets was dispensed on 05/04/2016.</p> <p>Further review of the controlled drug record for Resident #1's Clonazepam 0.5mg tablet revealed examples of inaccurate documentation to the controlled drug record included the following:</p> <ul style="list-style-type: none"> -On 05/01/2016 at 8:00am a handwritten entry was made for amount on hand of 9, amount received 45 tablets, amount given ½ tablet, amount remaining 44 and 1/2 tablets. There was no documentation adding the 9 tablets remaining to the 45 tablets received. The amount remaining should have been 54 tablets. -On 05/05/2016 at 4:00pm a handwritten entry was made for amount of 39 tablets, amount given ½ tablet, amount remaining 39 tablets. There was no accurate documentation for subtracting 	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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 367	<p>Continued From page 5</p> <p>the amount given from the amount on hand.</p> <p>-On 05/13/2016 at 8:00pm a handwritten entry was made for amount on hand of 26 and 1/2 tablets, amount given 1/2 tablet, amount remaining 26 tablets. On 05/14/2016 at 8:00am a handwritten entry was made for amount on hand of 35 tablets, amount given 1/2 tablet, amount remaining 34 and 1/2 tablets. There was no documentation for any amount received to increase the amount from 26 on 05/13/2016 at 8:00pm to 35 on 05/14/2016 at 8:00am.</p> <p>-On 05/17/2016 at 4:00pm there was a handwritten entry was made for amount on hand of 30 tablets, amount given 1/2 tablet, amount remaining 29 tablets. There was no accurate documentation for subtracting the amount given from the amount on hand. The amount remaining should have been 29 and 1/2 tablets.</p> <p>-On 05/17/2016 at 8:00pm there was a handwritten entry was made reflecting 9 tablets were added to the 29 tablets documented as remaining on 05/17/2016 at 4:00pm. It could not be determined where the 9 tablets were received from.</p> <p>-On 05/31/2016 at 8:00pm there was a handwritten entry for 16 tablets remaining. Written on the controlled drug record on the next line was "June script #15344" 8 and 1/2 tablets on hand, amount received was documented as 45 tablets. The total remaining was documented as 53 and 1/2 tablets. The amount remaining should have been documented as 61 tablets (45 + 16 = 61).</p> <p>-On 06/01/2016 at 8:00am there was handwritten entry was made for amount on hand of 53 and 1/2 tablets, amount given 1/2 tablet, amount remaining was documented as 53 and 1/2 tablets. There was no documentation subtracting the 1/2 tablet documenting as administered. The amount remaining should have been 53 tablets.</p>	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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 367	<p>Continued From page 6</p> <p>Observation of Resident #1's medications on hand on 06/08/2016 at 8:45am revealed there were 46 and 1/2 (93 halved Clonazepam 0.5mg) Clonazepam tablets on hand, not 43 as indicated on the controlled drug record.</p> <p>Interview with the Administrator on 06/08/2016 at 9:05am revealed:</p> <ul style="list-style-type: none"> -The Administrator did not know why there were more Clonazepam tablets on hand than indicated on the Controlled Substance Record. -A mistake may have been made when the Administrator initiated the Controlled Substance Record for Resident #1. -The Administrator thought 45 tablets of Clonazepam 0.5mg was dispensed each time from the pharmacy. -The Administrator added the 06/2016 supply of 45 Clonazepam 0.5mg tablets to the May 2016 controlled substance record because she did not have blank controlled drug record for use. -The Administrator counted the Clonazepam each time she administered from the medication. -The Administrator did not know why she had not recognized the inaccurate count unless she had been interrupted while counting and made an error. <p>Telephone interview with the Provider Pharmacy Representative (PPR) on 06/08/2016 at 11:45am revealed:</p> <ul style="list-style-type: none"> -The PPR dispensed the Clonazepam as 1/2 of a 0.5mg tablet. -The pharmacy dispensed a quantity of 45 Clonazepam 0.5mg tablets for Resident #1 to the facility on 04/04/2016 and 05/04/2016 which would be a 30 day supply for scheduled administration three times a day. -The PPR delivered medication to the facility 	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301
---	---

(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 367	<p>Continued From page 7</p> <p>every month.</p> <ul style="list-style-type: none"> -The PPR contacted the facility Administrator every month to review medication need before sending a supply of medications. -The PPR was not aware of and did not know why there were any medication discrepancies with Resident #1's Clonazepam 0.5mg tablets. <p>2. Review of Resident #2's current FL-2 dated 3/10/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included Schizoeffective Disorder Bipolar Type -There was a physician's order for Lorazepam 1mg two times a day (Lorazepam is used to treat anxiety). <p>Review of the May 2016 controlled substance log for Lorazepam for Resident #2 revealed:</p> <ul style="list-style-type: none"> -A pharmacy label on the controlled drug record indicated the supply of Lorezapam was dispensed on 5/6/16 with 60 tablets. -The first dose from the supply was on 5/6/16 at 8:00am. -There were 52 doses of Lorazepam documented as administered from 5/6/16-6/1/16. -Documentation on the controlled drug record after the 8:00am dose of Lorazepam on 6/1/16 indicated 9 tablets remained. <p>Observation of Resident #2's medications on 6/8/16 at 12:15pm revealed:</p> <ul style="list-style-type: none"> -One supply of Lorazepam 10mg tablets dispensed on 6/1/16 with a handwritten entry of 8:00am on the card and had 9 tablets remaining -Last dosage of Lorazepam 10mg tablet given was on 6/8/16 with a handwritten entry of 8:00am on the card with 54 tablets remaining -There were a total of 66 tablets of Lorazepam 10mg on hand. -The documentation on the Lorazepam controlled 	C 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL026037	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/08/2016
NAME OF PROVIDER OR SUPPLIER LEACH'S FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 413 COUNTRY CLUB DRIVE FAYETTEVILLE, NC 28301		
(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 367	<p>Continued From page 8</p> <p>drug record for Resident #2 of 66 tablets remaining at 8:00am on 6/8/16 did not match the on hand amount of 54 tablets of Lorazepam.</p> <p>Telephone interview with the Pharmacy Provider Representative (PPR) on 6/8/2016 at 11:25am revealed the pharmacy contacts the group home to determine what and how many pills are needed for each resident and medications were sent to the group home on 6/5/16.</p> <p>Interview with the Administrator/Med Aide on 6/8/16 at 12:35pm revealed: -The Administrator did not know why Resident #2's controlled drug record count for Lorazepam 10mg did not match the quantity on hand.</p>	C 367		