

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 C 06/10/2016
NAME OF PROVIDER OR SUPPLIER MINTZ FAMILY CARE HOME #4		STREET ADDRESS, CITY, STATE, ZIP CODE 192 MATO ROAD MARSHALL, NC 28755		
(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 a Complaint Investigation on June 7, 2016 with an exit conference via telephone, on June 10, 2016.	C 000		
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: TYPE B VIOLATION Based interviews and record review, the facility failed to notify the licensed prescribing practitioner for 1 of 3 residents (Resident #2) of a medication error which resulted in the resident being so sedated that she urinated in the bed, during the night, which was unusual for her. The findings are: Review of Resident #2's current FL2 dated 2/23/16 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), schizophrenia, bipolar disorder, insomnia, seizure disorder, tremors, and hypertension. -Medications included benztropine (used to control involuntary muscle contractions) 1mg twice daily, alprazolam (used to treat anxiety) 1mg twice daily, Invega (used to treat schizophrenia) 9mg at bedtime, melatonin (used to treat insomnia) 3mg at bedtime, Seroquel XR (used to treat bipolar disorder and schizophrenia) 300mg at bedtime, QVAR (used for treatment of COPD) 80mcg 1 puff twice daily, and phenytoin (used to treat seizure disorder) 100mg 3 capsules	C 246	See attached	7/25/16

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

Robert M. Clark Social Worker 7-31-16

TITLE (X8) DATE

STATE FORM

WP1311

If continuation sheet 1 of 14

Reviewed and accepted with corrections 8/19/16

Jennifer Fender RN

Mintz Family Care Home 4

Response to C 246 10A NCAC 13G.902(a) ^(b) ^{JF}

Administration has updated facility's policies to assure compliance in report medication errors. SIC and staff has been trained to these policies ~~(06/15/2016)~~ ^{JF} 7/25/16

Facility Social Worker is monitoring residents MARs and medications bi-monthly to assure medications are administrated as ordered ~~(06/15/2016)~~ ^{JF} Date of correction 7/25/16

Facility will implement additional training for staff and schedule Quality Improvement meetings. Facility will revise current policies to assure compliance to Declaration of Resident's Rights ~~(06/15/2016)~~ ^{JF} 7/25/16

Response to C 330 10A NCAC 13G.1004(a)

Refer to Response to C 246 10A NCAC 13G.902(a) ^(b) ^{JF} Date of correction 7/10/16

Response to C 912 G.S. 131D-21(2)

Facility will implement additional training for staff and schedule Quality Improvement meetings. Facility will revise current policies to assure compliance to Declaration of Resident's Rights ~~(06/15/2016)~~ ^{JF}

Dwight McClark
7-31-16

Reviewed and accepted with corrections.
8/19/16 @ 123pm Jennifer Fender RN

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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: TYPE B VIOLATION Based interviews and record review, the facility failed to notify the licensed prescribing practitioner for 1 of 3 residents (Resident #2) of a medication error which resulted in the resident being so sedated that she urinated in the bed, during the night, which was unusual for her. The findings are: Review of Resident #2's current FL2 dated 2/23/16 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), schizophrenia, bipolar disorder, insomnia, seizure disorder, tremors, and hypertension. -Medications included benztropine (used to control involuntary muscle contractions) 1mg twice daily, alprazolam (used to treat anxiety) 1mg twice daily, Invega (used to treat schizophrenia) 9mg at bedtime, melatonin (used to treat insomnia) 3mg at bedtime, Seroquel XR (used to treat bipolar disorder and schizophrenia) 300mg at bedtime, QVAR (used for treatment of COPD) 80mcg 1 puff twice daily, and phenytoin (used to treat seizure disorder) 100mg 3 capsules	C 246		7/25/16

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 246	Continued From page 1 at bedtime. Review of Resident #2's Medication Administration Records (MARs) for May 2016 revealed: -An entry for benzotropine 1mg twice daily at 8am and 8pm. -An entry for alprazolam 1mg twice daily for anxiety at 8am and 8pm. -An entry for Invega 9mg at 8pm. -An entry for melatonin 3mg at 8pm. -An entry for Seroquel XR 300mg at 8pm. -A handwritten star symbol in each of the boxes, for all of the above medications, for the 5/7/16 8:00pm dose. -A handwritten note at the bottom of the MAR with a star symbol and a "see note" handwritten beside of it. -There was no documentation on the MAR related to the disposition of the five medications that were scheduled to be administered on 5/7/16 at 8pm. Interview with the Supervisor in Charge (SIC) on 6/7/16 at 10:50am revealed: -The back-up SIC filled in as needed in the facility. -The back-up SIC gave Resident #2 all of another resident's 8:00pm medications in error on 5/7/16. -The back-up SIC called 911. -When Emergency Medical Services (EMS) arrived, they contacted the hospital and then Poison Control (PC). -PC reviewed all medications that were administered in error, and all medications that were to be administered at 8:00pm with the back-up SIC and EMS and instructed to hold all 8:00pm medications except for phenytoin and QVAR. -Resident #2 refused to go to the hospital.	C 246		

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C 246	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The Primary Care Provider (PCP) was not notified. -The SIC was unsure if there was a medication error report completed. -The medications administered in error made Resident #2 "sleepy, and she wet the bed that night, which was unusual for her." -"She was so sleepy she did not wake up to use the bathroom." <p>Interview with the back-up SIC on 6/7/16 and review of the May 2016 MAR (that belonged to another resident) revealed Resident #2 received the following 8pm medications in error on 5/7/16:</p> <ul style="list-style-type: none"> -Gabapentin (used to treat neuropathic pain) 400mg. -Topiramate (used to treat migraine headaches) 100mg. -Clonazepam (a long acting benzodiazepine used to treat anxiety) 1mg. -Quetiapine (used to treat bipolar disorder and schizophrenia) 600mg (normal dose was 300mg). -Benzotropine 1mg (normal dose). -Simvastatin 10mg. -Coface 100mg. -ACT anticavity fluoride rinse. <p>Interview with the back-up SIC on 6/7/16 at 2:01pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 took all 8pm medications that belonged to another resident on 5/7/16 (Saturday). -She immediately called 911, and when EMS arrived, they contacted PC. -PC reviewed both residents medications. -She was instructed by PC to hold all of Resident #2's medications except phenytoin and QVAR at 8pm on 5/7/16, and to resume her regular medications the next morning. -Resident #2 was sleeping so hard that she 	C 246		

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C 246	<p>Continued From page 3</p> <p>urinated in the bed, but "she was fine the next day."</p> <p>-She did not notify the PCP, "I just called EMS".</p> <p>-She completed a Medication Error/Reaction Form and faxed a copy to the Adult Home Specialist (AHS) and to the Assistant Administrator on 5/9/16 (Monday).</p> <p>-She did not know if the facility had a policy on medication errors.</p> <p>Interview with Resident #2 on 6/7/16 at 3:27pm revealed:</p> <p>-She was aware that she had taken another resident's medications on 5/7/16.</p> <p>-She felt "sleepy...I was messed up."</p> <p>-She stated she felt "better" the next day.</p> <p>-"I told EMS I was okay, I wanted to stay home, I just wanted to go to bed."</p> <p>-"It was an accident."</p> <p>-She did not know if her PCP had been notified.</p> <p>-The last time she went to the PCP's office was 5/25/16 to get an injection, she did not see the PCP that day.</p> <p>A second interview with the back-up SIC on 6/7/16 at 4:20pm revealed:</p> <p>-She was aware of the medication error on 6/7/16.</p> <p>-She realized the error had occurred when she handed the other resident the cup of 8pm medications and the other resident stated "these are not mine".</p> <p>-She immediately called 911.</p> <p>-She had mixed up the 2 residents medications for the 8pm medication pass on 5/7/16.</p> <p>-She was filling in for the SIC and did not routinely administer medications in this facility.</p> <p>Interview with the SIC on 6/7/16 at 4:25pm revealed he was in the facility the evening of</p>	C 246		
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C 246	<p>Continued From page 4</p> <p>5/7/16, but stated the back-up SIC administered the 8:00pm medications.</p> <p>Review of a Medication Error/Reaction Form for Resident #2 revealed:</p> <ul style="list-style-type: none"> - "Doing medication pass in kitchen, accidentally got fibromyalgia medicine and seizure medicine mixed up, gave wrong medicine." - "Called 911, EMS came out called poison control - no medicine I gave her would react with her daily medication, EMS spoke with [named staff] at Poison Control." - The resident's PCP was not notified. - The resident was not seen by a physician. - The form was dated 5/7/16 at 7:50pm and was faxed to the AHS on 5/9/16. <p>Interview with the back-up SIC on 6/8/16 at 11:35am and 1:10pm revealed:</p> <ul style="list-style-type: none"> - She administered all 8pm medications that belonged to another resident to Resident #2 on 5/7/16, "not just the fibromyalgia medications." - "I hadn't been dealing with medications that much, they both have the same first name (on the MARs), we have to call one [Resident #2's preferred name] and the other [the resident's preferred name]." - "As soon as I realized the error I stopped the medication pass and called EMS." <p>Interview with Resident #2's PCP on 6/8/16 at 8:26am and 2:50pm revealed:</p> <ul style="list-style-type: none"> - There was no documentation in their records, regarding notification from the facility, related to the medication error on 5/7/16. - The PCP considered this to be a significant medication error. - He agreed that the facility contacting EMS and Poison Control was appropriate. - Resident #2's most recent PCP visit was on 	C 246		

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C 246	<p>Continued From page 5</p> <p>5/2/16 and had not been in the office since the incident on 5/7/16.</p> <p>Interview with the Assistant Administrator on 6/8/16 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -She was aware of the medication error on 5/7/16. -The back-up SIC called her immediately when the error occurred. -"We have a policy and procedure on medication errors, it says to notify the MD, I don't think we did in that case and we should have." -She was unsure if the facility had talked to the PCP after the incident, and stated "I didn't think about it either." -It (the day of the medication error) was a Saturday or Sunday night." -"The next few days the resident was OK, I don't think after that I even thought about it anymore. I guess for [back-up SIC's name] that's what it was too." -She instructed the back-up SIC to notify the AHS on Monday 5/9/16 about the medication error. -"I can't believe it happened, I'm not sure if it had anything to do with the residents' having the same (first) name, when she told me it happened, I was like, how in the world did you do that?" -"I was flipping out, it's a very serious thing." -She was unable to provide the surveyor with the facility's medication policy. <hr/> <p>The facility provided a Plan of Protection on 6/10/16 that included:</p> <ul style="list-style-type: none"> -The Assistant Administrator will ensure all medications are administered as ordered by the PCP. -The Assistant Administrator will ensure all medication errors are reported to the PCP. -The Assistant Administrator will monitor home 	C 246		

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C 246	Continued From page 6 and communicate with staff on medication protocols. -The Assistant Administrator will review charts, MARs, and medications on hand bi-monthly. -The Assistant Administrator will provide an inservice to staff on medication administration policy and medication error reporting. -The Assistant Administrator will assure staff are aware of protocol and future measures. THE CORRECTION DATE FOR THIS TYPE B VIOLATION IS JULY 25, 2016.	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 A2 VIOLATION Based on interviews and record review, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 1 of 3 sampled residents (Resident #2), resulting in the resident being so sedated that she urinated in the bed, during the night, which was unusual for her. The findings are:	C 330		7/10/16

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C 330	<p>Continued From page 7</p> <p>Review of Resident #2's current FL2 dated 2/23/16 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included chronic obstructive pulmonary disease (COPD), schizophrenia, bipolar disorder, insomnia, seizure disorder, tremors, and hypertension. -Medications included benzotropine (used to control involuntary muscle contractions) 1mg twice daily, alprazolam (used to treat anxiety) 1mg twice daily, Invega (used to treat schizophrenia) 9mg at bedtime, melatonin (used to treat insomnia) 3mg at bedtime, Seroquel XR (used to treat bipolar disorder and schizophrenia) 300mg at bedtime, QVAR (used for treatment of COPD) 80mcg 1 puff twice daily, and phenytoin (used to treat seizure disorder) 100mg 3 capsules at bedtime. <p>Review of Resident #2's Medication Administration Records (MARs) for May 2016 revealed:</p> <ul style="list-style-type: none"> -An entry for benzotropine 1mg twice daily at 8am and 8pm. -An entry for alprazolam 1mg twice daily for anxiety at 8am and 8pm. -An entry for Invega 9mg at 8pm. -An entry for melatonin 3mg at 8pm. -An entry for Seroquel XR 300mg at 8pm. -A handwritten star symbol in each of the boxes, for all of the above medications, for the 5/7/16 8:00pm dose. -A handwritten note at the bottom of the MAR with a star symbol and a "see note" handwritten beside of it. -There was no documentation on the MAR related to the disposition of the five medications that were scheduled to be administered on 5/7/16 at 8pm. <p>Interview with the Supervisor in Charge (SIC) on</p>	C 330		

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C 330	<p>Continued From page 8</p> <p>6/7/16 at 10:50am revealed:</p> <ul style="list-style-type: none"> -The back-up SIC filled in as needed in the facility. -The back-up SIC gave Resident #2 all of another resident's 8:00pm medications in error on 5/7/16. -The back-up SIC called 911. -When Emergency Medical Services (EMS) arrived, they contacted the hospital and then Poison Control (PC). -PC reviewed all medications that were administered in error, and all medications that were to be administered at 8:00pm with the back-up SIC and EMS and instructed to hold all 8:00pm medications except for phenytoin and QVAR. -Resident #2 refused to go to the hospital. -The Primary Care Provider (PCP) was not notified. -The SIC was unsure if there was a medication error report completed. -The medications administered in error made Resident #2 "sleepy, and she wet the bed that night, which was unusual for her." -"She was so sleepy she did not wake up to use the bathroom." <p>Interview with the back-up SIC on 6/7/16 and review of the May 2016 MAR (that belonged to another resident) revealed Resident #2 received the following 8pm medications in error on 5/7/16:</p> <ul style="list-style-type: none"> -Gabapentin (used to treat neuropathic pain) 400mg. -Topiramate (used to treat migraine headaches) 100mg. -Clonazepam (a long acting benzodiazepine used to treat anxiety) 1mg. -Quetiapine (used to treat bipolar disorder and schizophrenia) 600mg (normal dose was 300mg). -Benzotropine 1mg (normal dose). -Simvastatin 10mg. 	C 330		

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C 330	<p>Continued From page 9</p> <ul style="list-style-type: none"> -Colace 100mg. -ACT anticavity fluoride rinse. <p>Interview with the back-up SIC on 6/7/16 at 2:01pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 took all 8pm medications that belonged to another resident on 5/7/16 (Saturday). -She immediately called 911, and when EMS arrived, they contacted PC. -PC reviewed both residents medications. -She was instructed by PC to hold all of Resident #2's medications except phenytoin and QVAR at 8pm on 5/7/16, and to resume her regular medications the next morning. -Resident #2 was sleeping so hard that she urinated in the bed, but "she was fine the next day." -She did not notify the PCP, "I just called EMS". -She completed a Medication Error/Reaction Form and faxed a copy to the Adult Home Specialist (AHS) and to the Assistant Administrator on 5/9/16 (Monday). -She did not know if the facility had a policy on medication errors. <p>Interview with Resident #2 on 6/7/16 at 3:27pm revealed:</p> <ul style="list-style-type: none"> -She was aware that she had taken another resident's medications on 5/7/16. -She felt "sleepy...I was messed up." -She stated she felt "better" the next day. -"I told EMS I was okay, I wanted to stay home, I just wanted to go to bed." -"It was an accident." -She did not know if her PCP had been notified. -The last time she went to the PCP's office was 5/25/16 to get an injection, she did not see the PCP that day. 	C 330		

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C 330	<p>Continued From page 10</p> <p>A second interview with the back-up SIC on 6/7/16 at 4:20pm revealed: -She was aware of the medication error on 6/7/16. -She realized the error had occurred when she handed the other resident the cup of 8pm medications and the other resident stated "these are not mine". -She immediately called 911. -She had mixed up the 2 residents medications for the 8pm medication pass on 5/7/16. -She was filling in for the SIC and did not routinely administer medications in this facility.</p> <p>Interview with the SIC on 6/7/16 at 4:25pm revealed he was in the facility the evening of 5/7/16, but stated the back-up SIC administered the 8:00pm medications.</p> <p>Review of a Medication Error/Reaction Form for Resident #2 revealed: -"Doing medication pass in kitchen, accidentally got fibromyalgia medicine and seizure medicine mixed up, gave wrong medicine." -"Called 911, EMS came out called poison control - no medicine I gave her would react with her daily medication, EMS spoke with [named staff] at Poison Control." -The resident's PCP was not notified. -The resident was not seen by a physician. -The form was dated 5/7/16 at 7:50pm and was faxed to the AHS on 5/9/16.</p> <p>Interview with the back-up SIC on 6/8/16 at 11:35am and 1:10pm revealed: -She administered all 8pm medications that belonged to another resident to Resident #2 on 5/7/16, "not just the fibromyalgia medications." -"I hadn't been dealing with medications that much, they both have the same first name (on the</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 C 06/10/2016
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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	<p>Continued From page 11</p> <p>MARs), we have to call one [Resident #2's preferred name] and the other [the resident's preferred name]."</p> <p>- "As soon as I realized the error I stopped the medication pass and called EMS."</p> <p>Interview with Resident #2's PCP on 6/8/16 at 8:26am and 2:50pm revealed:</p> <p>- There was no documentation in their records, regarding notification from the facility, related to the medication error on 5/7/16.</p> <p>- The PCP considered this to be a significant medication error.</p> <p>- He agreed that the facility contacting EMS and Poison Control was appropriate.</p> <p>- Resident #2's most recent PCP visit was on 5/2/16 and had not been in the office since the incident on 5/7/16.</p> <p>Interview with the Assistant Administrator on 6/8/16 at 2:10pm revealed:</p> <p>- She was aware of the medication error on 5/7/16.</p> <p>- The back-up SIC called her immediately when the error occurred.</p> <p>- "We have a policy and procedure on medication errors, it says to notify the MD, I don't think we did in that case and we should have."</p> <p>- She was unsure if the facility had talked to the PCP after the incident, and stated "I didn't think about it either."</p> <p>- It (the day of the medication error) was a Saturday or Sunday night."</p> <p>- "The next few days the resident was OK, I don't think after that I even thought about it anymore. I guess for [back-up SIC's name] that's what it was too."</p> <p>- She instructed the back-up SIC to notify the AHS on Monday 5/9/16 about the medication error.</p> <p>- "I can't believe it happened, I'm not sure if it had</p>	C 330		

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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 C 06/10/2016
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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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C 330	<p>Continued From page 12</p> <p>anything to do with the residents' having the same (first) name, when she told me it happened, I was like, how in the world did you do that?" -"I was flipping out, it's a very serious thing." -She was unable to provide the surveyor with the facility's medication policy.</p> <hr/> <p>The facility provided a Plan of Protection on 6/10/16 that included: -The Assistant Administrator will ensure all medications are administered as ordered by the PCP. -The Assistant Administrator will ensure all medication errors are reported to the PCP. -The Assistant Administrator will monitor home and communicate with staff on medication protocols. -The Assistant Administrator will review charts, MARs, and medications on hand bi-monthly. -The Assistant Administrator will provide an inservice to staff on medication administration policy and medication error reporting. -The Assistant Administrator will assure staff are aware of protocol and future measures.</p> <p>THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION IS JULY 10, 2016.</p>	C 330		
C 912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p>	C 912		

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 C 06/10/2016
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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C 912	<p>Continued From page 13</p> <p>This Rule is not met as evidenced by: Based on 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 and Health Care for 1 of 3 residents. (Resident #2).</p> <p>The findings are:</p> <p>A. Based on interviews and record review, the facility failed to notify the licensed prescribing practitioner for 1 of 3 residents (Resident #2) of a medication error which resulted in the resident being so sedated that she urinated in the bed, during the night, which was unusual for her. [Refer to Tag 246, 10A NCAC 13G .0902(b) Health Care (Type B Violation)].</p> <p>B. Based on interviews and record review, the facility failed to assure medications were administered as ordered by a licensed prescribing practitioner to 1 of 3 sampled residents (Resident #2), resulting in the resident being so sedated that she urinated in the bed, during the night, which was unusual for her[Refer to Tag 330, 10A NCAC 13G .1004(a) Medication Administration (Type A2 Violation)].</p>	C 912		