

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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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 and complaint investigation on 07/14/16, 07/18/16, 07/21/16, and 07/28/16.	C 000		
C 074	<p>10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings</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: TYPE B VIOLATION</p> <p>Based on observations and interviews, the facility failed to assure the walls were clean and in good repair in 3 of 3 resident bedrooms, the common resident bathroom, living room and hallway, and the ceiling was in clean and in good repair in the living room and bathroom, and the floors were clean and in good repair in the 2 of 3 resident bedrooms, the common bathroom, and the kitchen.</p> <p>The findings are:</p> <p>1. Observation of the walls and doors during the initial facility tour on 07/14/16 from 9:45am-10:05am revealed: -The front entry door was dirty with light tan and brown colored stains on the outside surface and the paint on the trim around the door was not intact. -The surface of the door was not even; there were indentions in the door on the right panel.</p>	C 074		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

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C 074	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-The inside surface of the front door had light tan colored stains around the door knob which extended down the door towards the floor.</li> <li>-The trim work around the door was dirty and the paint was not intact.</li> <li>-There was a build-up of dust and dirt along the living room walls at the baseboard trim work closest to the floors.</li> <li>-There was white colored spackling measuring the diameter of a canned drink (6 inches) on the living room wall to the right side of the entry door.</li> <li>-There was white colored spackling on the hallway wall on the right side of the thermostat measuring 8 inches in diameter.</li> <li>-In the first bedroom on the left of the hall, the door had black colored stains of various sizes and the paint on the walls around the bed sitting on the right side of the room was chipped and not intact.</li> <li>-In the second bedroom on the left of the hall, the door had 3 black colored stains and various other white and light colored stains and there was dirt and dust build-up along the baseboard trim work.</li> <li>-In the third bedroom on the right side of the hall, there was white colored spackling measuring approximately 8 inches by 10 inches on the door, the left wall had a dent in it the size of a soda can, but the paint was intact; on the right wall near the floor, the paint was not intact.</li> <li>-The bathroom walls did not have an even surface around the windows and shower insert and the paint was peeling and/or not intact in some places.</li> <li>-The bathroom walls contained white spackling around almost the perimeter of the shower insert and grab bar.</li> <li>-There were black colored stains on the wall behind the toilet.</li> <li>-The paint on the bathroom vanity sink cabinet was not intact in spots and there were dark brown</li> </ul>	C 074		

Division of Health Service Regulation

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C 074	<p>Continued From page 2</p> <p>colored stains/scuff marks on the left side of the vanity cabinet.</p> <p>- There was a build-up of dirt along the bathroom walls at the baseboard trim work closet to the floors.</p> <p>Observation of the hallway on 7/28/16 at 3:45pm revealed:</p> <p>-The air condition vent on the right side of the wall was covered by a black substance.</p> <p>-There was dust covering the entire front part of the air condition vent and around the edges that were flush with the wall.</p> <p>Review of on an entry in the staff note book dated 04/02/16 revealed Resident #2 knocked a hole in the wall "by the front door."</p> <p>Refer to the confidential resident interviews.</p> <p>Refer to the two confidential staff interviews.</p> <p>Refer to the telephone interview with a visitor on 07/28/16 at 10:47am.</p> <p>Refer to the telephone interview with representative of the building owner/landlord on 07/27/16 at 9:48am.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:48pm.</p> <p>Refer to the interview with the Administrator on 07/18/16 at 9:05am.</p> <p>Refer to the interview with the Administrator on 07/28/16 at 4:40pm.</p> <p>Refer to observation of the Administrator on 07/28/16 at 6:00pm.</p>	C 074		

Division of Health Service Regulation

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C 074	<p>Continued From page 3</p> <p>2. Observation of the ceilings during the initial facility tour on 07/14/16 from 9:45am-10:05am revealed: -The ceiling in the living room above the front door was cracking and contained a spackling material that was approximately 10 inches in diameter. -The ceiling in the bathroom had light tan and yellowish colored discoloration above the shower.</p> <p>Refer to the confidential resident interviews.</p> <p>Refer to the telephone interview with a visitor on 07/28/16 at 10:47am.</p> <p>Refer to the two confidential staff interviews.</p> <p>Refer to the telephone interview with representative of the building owner/landlord on 07/27/16 at 9:48am.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:48pm</p> <p>Refer to the interview with the Administrator on 07/18/16 at 9:05am.</p> <p>Refer to the interview with the Administrator on 07/28/16 at 4:40pm.</p> <p>Refer to observation of the Administrator on 07/28/16 at 6:00pm.</p> <p>3. Observation of the floors during the initial facility tour on 07/14/16 revealed: -The floor at the entrance to the first bedroom on the left of the hall had a give to it when it was stood on, but the floor covering was intact.</p>	C 074		

Division of Health Service Regulation

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C 074	<p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-There was red colored tape on the floor on the right side of the window.</li> <li>-The floor in the second bedroom on the left of the hall was dirty with debris and sticky when walked on.</li> <li>-There was a section of floor covering in the kitchen near the refrigerator that was not intact.</li> <li>-The bathroom floor was sticky when walked on.</li> </ul> <p>Observation of the floor in the living room on 7/28/16 at 3:45pm revealed there was an approximate 3 inch gash in the floor covering in front of the couch with the edges peeled upward.</p> <p>Refer to the confidential resident interviews.</p> <p>Refer to the two confidential staff interviews.</p> <p>Refer to the telephone interview with representative of the building owner/landlord on 07/27/16 at 9:48am.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:48pm.</p> <p>Refer to the interview with the Administrator on 07/18/16 at 9:05am.</p> <p>Refer to the interview with the Administrator on 07/28/16 at 4:40pm.</p> <p>Refer to observation of the Administrator on 07/28/16 at 6:00pm.</p> <p>_____</p> <p>Confidential interview with 3 residents revealed:</p> <ul style="list-style-type: none"> <li>-Two (named) residents punched holes in the walls and doors.</li> <li>-The residents did not know how long the holes</li> </ul>	C 074		

Division of Health Service Regulation

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C 074	<p>Continued From page 5</p> <p>were in the walls before they were patched.</p> <ul style="list-style-type: none"> <li>-The holes had been patched/spackled 1 month ago.</li> <li>-The bathroom walls and ceiling had " always" been like that.</li> <li>-The bathroom " was gross."</li> <li>-" Sometimes" staff swept and mopped the floors.</li> <li>-Nobody would want to live in the facility.</li> </ul> <p>Telephone interview with a visitor on 07/28/16 at 10:47am revealed:</p> <ul style="list-style-type: none"> <li>-The visitor visited the home approximately three weeks ago.</li> <li>-" I can't believe a state inspector would pass this place."</li> <li>-The facility was uninhabitable; " I wouldn't let my pet stay there."</li> <li>-There were exposed wires dangling from the fluorescent lights in the kitchen.</li> <li>-" I was floored and could not believe people were living in those conditions."</li> <li>-" The governor would not like this."</li> </ul> <p>Confidential interviews with a staff member revealed:</p> <ul style="list-style-type: none"> <li>-The paint on the bathroom walls had been like that for a year or more.</li> <li>-Two weeks to one month ago, the spackling material was added to the walls at the shower insert.</li> <li>-The spackling in the living room, hallway, and bedroom door " were holes from when residents punched the wall."</li> <li>-The spackling was put in the holes " 2 weeks ago;" prior to the spackling, holes were present.</li> <li>-The chipped paint in the first bedroom was caused by a former resident taking a hanger and scratching the wall.</li> <li>-Staff were responsible for cleaning and mopping</li> </ul>	C 074		

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C 074	<p>Continued From page 6</p> <p>the floors.</p> <ul style="list-style-type: none"> <li>-Floors were mopped daily but had not been mopped yet that day. (Date withheld to maintain staff confidentiality).</li> <li>-The Administrator was aware of the condition of the facility's walls, floors, and ceilings.</li> </ul> <p>Confidential interview with a second staff member revealed:</p> <ul style="list-style-type: none"> <li>-The staff member did not know how long the walls in the bedrooms, bathroom, hall, and living room had been that way.</li> <li>-The patch on the living room wall had been there for three months.</li> <li>-The staff member did not know how long the bathroom had been that way.</li> <li>-The SIC and Administrator were aware of the condition of the walls, floors, and ceilings.</li> </ul> <p>Telephone interview with a representative of the building owner/Landlord on 07/27/16 at 9:48am revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator was responsible for assuring repairs related to the general wear and tear of the facility were fixed.</li> <li>-The Administrator was responsible for repairing damages made by the residents of the home such as holes in the walls and painting.</li> <li>-The Administrator was aware of the repairs she was responsible for because the Landlord Representative had discussed it with the Administrator " earlier in the year."</li> </ul> <p>Interview with the Administrator on 07/14/16 at 1:48pm revealed:</p> <ul style="list-style-type: none"> <li>-The facility recently had multiple repairs completed after a construction survey.</li> <li>-The Administrator thought everything was " ok" with the housekeeping and furnishings.</li> <li>-The Administrator was not allowed to paint the</li> </ul>	C 074		

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C 074	<p>Continued From page 7</p> <p>walls or ceilings due to the lease agreement. -The owner of the building was responsible for any repairs in the facility.</p> <p>Interview with the Administrator on 07/18/16 at 9:05am revealed: -The Administrator had not received any complaints from residents about the floors, walls, or ceilings. -The Administrator thought the facility was " up to par." -" Last week" a man came to the facility with his family member to look into admitting his family member; the man told the Administrator the " state of the building" was " not up to par" and did not admit his family member. -The floors were supposed to be cleaned every shift.</p> <p>Interview with the Administrator on 07/28/16 at 4:40pm. Revealed: -The Administrator was not aware the facility was " not up to par." -The Administrator would talk to the landlord/owner of the building to complete repairs.</p> <p>Observation of the Administrator on 07/28/16 at 6:00pm: -The Administrator called the Landlord representantive regarding the water pressure. -The Administrator informed the Landlord representative that the water pressure was slow and would cut off when residents bathed.</p> <p>Review of the Plan of Protection submitted by the facility on 07/28/16 revealed: -All staff would assure the facility was cleaned on each shift before leaving.</p>	C 074		

Division of Health Service Regulation

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C 074	Continued From page 8  -All painting and repairs would be completed by the owner of the building.  THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED 09/11/16.	C 074		
C 075	10A NCAC 13G .0315(a)(2) Housekeeping and Furnishings  10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing homes.  This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure 1 of 3 resident bedrooms was free of chronic unpleasant odors.  The findings are:  Observation on the facility tour on 07/14/16 revealed the second bedroom on the left smelled of body odor and feces.  Confidential interview with 2 residents revealed the two residents did not have any complaints about the odor in the bedroom.  Observation on 07/14/16 at 09:30am revealed: -A staff and the Supervisor-in-Charge, cleaned the bedroom and removed excess items out of the bedroom. -The odor continued to permeate the room after staff completed cleaning the room.  Confidential interview with a staff member	C 075		

Division of Health Service Regulation

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C 075	<p>Continued From page 9</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-The odor in the bedroom had "been like that a long time."</li> <li>-Resident #4 slept in the bedroom with the odor.</li> <li>-Residents had complained about Resident #4's body odor.</li> <li>-Resident #4 "doesn't like to wash."</li> <li>-Staff had cleaned the bedroom and changed the linen but the odor would not go away.</li> <li>-The staff thought the bedroom smelled bad because Resident #4 was not bathing.</li> </ul> <p>Confidential interview with a second staff member revealed:</p> <ul style="list-style-type: none"> <li>-The two residents who lived in the bedroom would not take a bath.</li> <li>-It "smells terrible in there."</li> </ul> <p>Telephone interview with a resident's family member on 07/26/16 as 1:02pm revealed:</p> <ul style="list-style-type: none"> <li>-"The place was not sanitary."</li> <li>-"There would be a terrible stench in there."</li> </ul> <p>Telephone interview with a visitor on 07/28/16 at 10:47am revealed that when the visitor walked into the home, "the stench, oh my God."</p> <p>Interview with the SIC on 07/14/16 at 9:30am revealed staff had attempted to keep the bedroom clean and odor free but the odor would not go away because the resident who resided in the room would not take a shower like he was supposed to.</p>	C 075		
C 076	<p>10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings</p> <p>10A NCAC 13G .0315 Housekeeping and Furnishings</p>	C 076		

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C 076	<p>Continued From page 10</p> <p>(a) Each family care home shall: (3) have furniture 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 observations and interviews, the facility failed to assure the furniture in the common living room and 3 of 3 residents' bedrooms was in good repair and clean.</p> <p>The findings are:</p> <p>Observation on 07/14/16 during the initial facility tour revealed: -The chest of drawers in the first bedroom on the left of the hallway was missing the bottom right drawer. -The chest of drawers in bedroom on the right of the hallway had two broken, uneven drawers. -The sofa and loveseat in the living room had multiple small brown colored stains on the cushions. -The over head light in the living room did not work.</p> <p>Observation of the living room on 07/28/16 at 3:35pm revealed: -The couch had a tear the length of the back cushion with an area approximately 3 inches long by 2 inches wide that had the stuffing exposed and hanging out. -There was an area approximately the size of a quarter on the seat cushion of the couch that was torn and stuffing was exposed.</p> <p>Confidential interview with a resident revealed: -A resident broke the chest of drawers. -Nobody would want to live in the facility with the furniture the way it was.</p>	C 076		

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C 076	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-The SIC and Administrator knew about the furniture.</li> <li>-"Somebody needs to fix it."</li> </ul> <p>Confidential interview with a second resident revealed the living room light "has never worked."</p> <p>Telephone interview with a visitor on 07/28/16 at 10:47am revealed:</p> <ul style="list-style-type: none"> <li>-The visitor visited the home approximately three weeks ago.</li> <li>-"I can't believe a state inspector would pass this place."</li> <li>-The facility was uninhabitable; "I wouldn't let my pet stay there."</li> <li>-"I was floored and could not believe people were living in those conditions."</li> <li>-The furniture was old and dilapidated throughout.</li> <li>-The bed in one of the rooms looked "collapsed, like it would fall to the floor if someone sat on it."</li> <li>-"The governor would not like this."</li> </ul> <p>Telephone interview with a resident's family member on 07/28/16 at 5:30pm revealed:</p> <ul style="list-style-type: none"> <li>-The family member first visited the facility around the beginning of 2014, but the cleanliness of the facility was a concern each time the family member visited.</li> <li>-There was only one couch in the living room.</li> <li>-There were not enough dining room chairs to accommodate all the residents that lived in the home.</li> <li>-"I know they are all not going to sit down at the same time, but still. What if visitors came to visit, where would they sit? "</li> </ul> <p>Telephone interview with a second resident's family member on 07/26/16 at 1:02pm revealed the furniture in the facility "was falling apart."</p>	C 076		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 076	<p>Continued From page 12</p> <p>Confidential staff interview revealed: -The light in the living room had not worked as long as the staff could remember. -The staff did not know what was wrong with the light. -The Administrator was aware the light did not work. -The dining room light had recently been repaired and the staff wondered why the living room light was not repaired. -The living room furniture had been in that condition since the staff member started working there.</p> <p>Interview with the Administrator on 07/14/16 at 1:48pm revealed the Administrator thought everything was "ok" with the housekeeping and furnishings.</p> <p>Interview with the Administrator on 07/28/16 at 4:40pm revealed the Administrator was not aware the facility was "not up to par."</p>	C 076		
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: TYPE B VIOLATION</p>	C 078		

Division of Health Service Regulation

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C 078	<p>Continued From page 13</p> <p>Based on observations and interviews, the facility failed to assure the facility bathroom, kitchen, living room, 3 of 3 resident bedrooms, and outside grounds were kept clean, uncluttered, and free of hazards.</p> <p>The findings are:</p> <p>Review of the "Resident Contract" revealed the facility offered services including "housekeeping."</p> <p>1. Observation of the common resident bathroom during the facility tour on the 07/14/16 revealed:</p> <ul style="list-style-type: none"> <li>-The bathroom floor was sticky when walked on.</li> <li>-The toilet bowl was covered in rust stains and contained a brown colored stain/build-up around the diameter of the bowl.</li> <li>-The vanity sink had rust colored stains.</li> <li>-There were black colored stains on the wall behind the toilet.</li> <li>-There were dark brown colored stains/scuff marks on the left side of the vanity cabinet.</li> <li>- There was a build-up of dirt along the bathroom walls at the baseboard trim work closet to the floors.</li> <li>-The baseboard heat cover underneath the window was rusted and covered in a dark brown substance.</li> <li>-The entire shower head was covered in a brown colored substance.</li> <li>-The shower had tan and brown colored grime and soap scum build-up.</li> <li>-The teal colored plastic shower curtain contained light tan, white, and light greenish colored mold and mildew near the bottom which extended mid-way up the shower curtain.</li> <li>-The window blind had three broken slats towards the middle of the blind, compromising privacy.</li> </ul> <p>Confidential interview with a resident revealed the bathroom was "gross."</p>	C 078		

Division of Health Service Regulation

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C 078	<p>Continued From page 14</p> <p>Confidential interview with a second resident revealed the tub was not kept clean and "they never clean the bathroom."</p> <p>Confidential interview with a third resident revealed the shower curtain was dirty and had greenish, crusty stains on it.</p> <p>Refer to the telephone interview with the family member on 07/26/16 at 1:02pm.</p> <p>Refer to the telephone interview with a visitor on 07/28/16 at 10:47am.</p> <p>Confidential staff interview revealed: -The staff did not know the last time the bathroom had been cleaned. -First shift staff was responsible for cleaning the bathroom.</p> <p>Refer to the interview with the Supervisor in Charge (SIC) on 07/28/16 at 3:30pm.</p> <p>Interview with the Administrator on 07/018/16 at 09:05am revealed the Administrator would check on the bathroom cleanliness and change the bathroom blind.</p> <p>Observation of the bathroom on 07/28/16 at 06:37am revealed: -The bathroom shower had still not been cleaned and contained soap scum and grime. -The same teal colored shower curtain was still being used; the mold and mildew was still present. -The window blind was still broken.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:48pm.</p>	C 078		

Division of Health Service Regulation

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C 078	<p>Continued From page 15</p> <p>Refer to the interview with the Administrator on 07/28/16 at 4:40pm.</p> <p>2. Observation of the kitchen on the facility tour on 07/14/16 revealed:</p> <ul style="list-style-type: none"> <li>-The stove burners were dirty and covered with brown colored stains.</li> <li>-The inside of the oven was dirty and discolored with brown and black stain.</li> <li>-The oven door and window had grease and brown colored stains.</li> <li>-The filter in the stove hood was greasy and had black and rust colored stains.</li> <li>-The refrigerator had a chain with a lock was hanging from the handle.</li> <li>-The cabinet underneath the kitchen sink had unknown debris and brown and white colored stains inside it.</li> <li>-The metal oven rack was sitting on the floor, propped against the wall.</li> <li>-There were four bags of trash sitting on the kitchen floor</li> </ul> <p>Review of an entry in the staff communication notebook dated 05/23/16 revealed:</p> <ul style="list-style-type: none"> <li>-"Staff please keep refrigerator lock [sic] up at all times [sic] unless you in the kitchen other wise [sic] lock it up. If I come down here and it unlock [sic] you will be written up."</li> <li>-"The client is [sic] drinking up everything. [Administrator's name] can't keep buying..."</li> <li>-The entry was signed by the Supervisor in Charge.</li> </ul> <p>Observation of the refrigerator in the kitchen on 07/28/16 at 7:00am revealed a chain with a lock was hanging from the handle.</p> <p>Confidential resident interview revealed the staff</p>	C 078		

Division of Health Service Regulation

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C 078	<p>Continued From page 16</p> <p>never clean up anything; the staff only mopped the floors and cleaned the stove.</p> <p>Refer to the telephone interview with the family member on 07/26/16 at 1:02pm.</p> <p>Telephone interview with a visitor on 07/28/16 at 10:47am revealed: -The kitchen stove, "Oh my God;" it looked like it had never been cleaned. -The refrigerator was chained and it "actually scared me" that a chain was hanging by a lock on the refrigerator.</p> <p>Refer to the interview with the SIC on 07/28/16 at 3:30pm.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:48pm.</p> <p>Refer to the interview with the Administrator on 07/28/16 at 4:40pm.</p> <p>_____ Confidential interview with 3 residents revealed: -One resident never saw the staff clean anything but the floors; "They just spray stuff." -Staff were "never" observed cleaning the facility. -Staff never dusted or clean the bathroom. -The staff only mopped the floors and cleaned the stove. -One of the residents recalled assisting the SIC to clean the facility.</p> <p>Telephone interview with a resident's family member on 07/26/16 as 1:02pm revealed the facility was not kept clean and "was not sanitary."</p> <p>Telephone interview with a visitor on 07/28/16 at 10:47am revealed:</p>	C 078		

Division of Health Service Regulation

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C 078	<p>Continued From page 17</p> <ul style="list-style-type: none"> <li>-The visitor visited the home approximately three weeks ago.</li> <li>-"I can't believe a state inspector would pass this place."</li> <li>-The facility was uninhabitable; "I wouldn't let my pet stay there."</li> <li>-"I was floored and could not believe people were living in those conditions."</li> <li>-"The governor would not like this."</li> </ul> <p>Confidential interview with two staff members revealed:</p> <ul style="list-style-type: none"> <li>-Staff were responsible for keeping the facility clean.</li> <li>-Staff were responsible for all of the cleaning and mopping the floors.</li> <li>-First shift was responsible for most of the facility cleaning.</li> <li>-Staff did not know the last time the facility was dusted and cleaned.</li> </ul> <p>Interview with the Supervisor in Charge (SIC) on 07/28/16 at 3:30 revealed the SIC had not received any complaints about the facility furnishings.</p> <p>Interview with the Administrator on 07/14/16 at 1:48pm revealed the Administrator thought everything was "ok" with the housekeeping and furnishings.</p> <p>Interview with the Administrator on 07/28/16 at 4:40pm revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator had not had any complaints from any resident on the cleanliness of the facility.</li> <li>-The staff on duty was responsible for cleaning the facility on each shift before they left.</li> </ul> <p>Review of the Plan of Protection submitted by the</p>	C 078		

Division of Health Service Regulation

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C 078	Continued From page 18 facility on 07/28/16 revealed: -All staff would assure the facility was cleaned on each shift before leaving.  THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED 09/11/16.	C 078		
C 086	10A NCAC 13G .0315(b)(1) Housekeeping and Furnishings  10A NCAC 13G .0315 Housekeeping and Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed is to have the following: This rule apply to new and existing homes. (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed;  This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the mattress in 1 of 3 resident bedrooms was in good repair. The findings are:  Observation of the second bedroom on the left side of the hallway on 07/14/16 during the initial facility tour revealed the mattress on the bed on the right side of the room was sagging and had	C 086		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 086	<p>Continued From page 19</p> <p>exposed coils.</p> <p>Interview with a resident on 07/18/16 at 7:05am revealed: -The mattress had been that way " for months." -The mattress was uncomfortable to sleep on, and hurt his back. -The Supervisor in Charge (SIC) and Administrator were aware of the condition of the mattress, but they don't give a [expletive] about us."</p> <p>Telephone interview with a visitor on 07/28/16 at 10:47am revealed: -The visitor visited the home approximately three weeks ago. -The furniture was old and dilapidated throughout. -The bed in one of the rooms looked "collapsed, like it would fall to the floor if someone sat on it."</p> <p>Interview with the Supervisor in Charge (SIC) on 07/28/16 at 3:30 revealed the SIC had not received any complaints about the facility furnishings.</p> <p>Interview with the Administrator on 07/14/16 at 1:48pm revealed the Administrator thought everything was "ok" with the housekeeping and furnishings.</p>	C 086		
C 090	<p>10A NCAC 13G .0315(b)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13G .0315 Housekeeping and Furnishings (b) Each bedroom shall have the following furnishing in good repair and clean for each resident: (5) a minimum of one comfortable chair (rocker</p>	C 090		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 090	<p>Continued From page 20</p> <p>or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; This rule 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 assure 3 of 3 resident bedrooms were furnished with at least one comfortable chair.</p> <p>The findings are:</p> <p>Observation during the facility tour on 07/14/16 revealed 3 of 3 resident bedrooms were not furnished with a chair.</p> <p>Confidential staff interview revealed: -The chairs that were currently sitting outside of the facility used to be dining room chairs. -There were not enough dining room chairs, so the Supervisor In Charge (SIC) had staff remove the chairs out of the bedrooms and into the dining room.</p> <p>Interview with the SIC on 07/28/16 at 3:40pm revealed: -The SIC was not aware all bedrooms were supposed to be furnished with a chair. -The SIC had no knowledge of chairs being moved from the resident bedrooms into the dining room.</p>	C 090		
C 097	<p>10A NCAC 13G .0316 (b) Fire Safety And Disaster Plan</p> <p>10A NCAC 13G .0316 Fire Safety And Disaster Plan</p> <p>(b) The building shall be provided with smoke detectors as required by the North Carolina State</p>	C 097		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 097	<p>Continued From page 21</p> <p>Building Code and U.L. listed heat detectors connected to a dedicated sounding device located in the attic and basement. These detectors shall be interconnected and be provided with battery backup.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews, record reviews, and observations, the facility failed to replace the batteries in one smoke detector in order to maintain a working fire alarm system. The findings are:</p> <p>Observation upon entering the facility on 07/14/16 at 06:45am revealed there was chirping sound heard every few seconds.</p> <p>Interview with a resident on 07/14/16 at 06:55am revealed the chirping sound was coming from the "fire alarm" in the living room.</p> <p>Observation throughout the day on 07/14/16 until exit at 2:15pm revealed the smoke detector in the hallway continued to chirp every few seconds.</p> <p>Interview with the Administrator on 07/14/16 at 12:45pm revealed: -The smoke detector batteries had been changed "recently" but the Administrator did not know when. -The smoke detector needed a specific brand of batteries.</p> <p>Observation throughout the day on 07/18/16 from 7:00am-11:30am revealed the smoke detector in the hallways made a chirping sound every few</p>	C 097		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 097	<p>Continued From page 22</p> <p>seconds in the same manner heard on 07/14/16.</p> <p>Observation of the facility on 07/28/16 from 7:00am-9:15am revealed the smoke detector in the hallway continued to make a chirping sound every few seconds in the same manner heard on 07/14/16 and 07/18/16.</p> <p>Confidential interviews with three residents revealed:</p> <ul style="list-style-type: none"> <li>-The smoke detector chirped all the time.</li> <li>-Two of three resident reported the chirping smoke detector bothered them.</li> <li>-"I hate that thing. It's been like that ever since I got here."</li> <li>-"It really kicks off when they cook in the kitchen."</li> <li>-The smoke detector had been chirping "awhile" but it did not bother one resident.</li> </ul> <p>Telephone interview with a resident's family member on 07/28/16 at 5:30pm revealed when the family member first visited the facility in February 2014, the smoke detector was "beeping on and off like the battery was dead."</p> <p>Confidential interview with a staff member revealed:</p> <ul style="list-style-type: none"> <li>-The smoke detector beeped "all the time."</li> <li>-The Administrator and Supervisor-In-Charge (SIC) were aware.</li> <li>-The last time the batteries were changed in the smoke detector was 2 months ago.</li> <li>-The county Department of Social Services (DSS) Adult Home Specialist (AHS) had brought it to staff's attention a "few months ago."</li> </ul> <p>Confidential interview with a second staff member revealed:</p> <ul style="list-style-type: none"> <li>-The chirping sound was coming from the smoke detector.</li> <li>-The smoke detector had been chirping "24/7"</li> </ul>	C 097		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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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 097	<p>Continued From page 23</p> <p>(twenty four hours a day, 7 days per week) "forever."</p> <ul style="list-style-type: none"> <li>-The smoke detector kept staff and residents awake.</li> <li>-The only person that was not kept awake by the chirping smoke detector was Resident #2 because Resident #2 was a heavy sleeper.</li> <li>-The staff did not know why the Administrator would not fix the smoke detector.</li> </ul> <p>Interview with the Administrator on 07/28/16 at 4:30pm revealed there was "nothing wrong" with the smoke detector; the smoke detector "just needs a new battery."</p> <p>Review of the Plan of Protection submitted by the facility dated 07/28/16 revealed:</p> <ul style="list-style-type: none"> <li>-Staff would change the battery in the smoke detector.</li> <li>-If the smoke detector continued to beep after the battery was changed, the Administrator would contact the electrician to check the smoke detector.</li> </ul> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 09/11/16.</p>	C 097		
C 100	<p>10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan</p> <p>10A NCAC 13G .0316 Fire Safety And Disaster Plan</p> <p>(e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members</p>	C 100		

Division of Health Service Regulation

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C 100	<p>Continued From page 24</p> <p>present, and a short description of what the rehearsal involved.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, record reviews, and interviews, the facility failed to assure fire drills were completed quarterly in 2015 and 2016.</p> <p>The findings are:</p> <p>Confidential interviews with four residents revealed:</p> <ul style="list-style-type: none"> <li>-Four of four residents interviewed reported they had never observed or participated in a fire drill at the facility.</li> <li>-The residents had never been told what to do in the event of a fire.</li> <li>-"I know what to do, get out."</li> </ul> <p>Review of the facility's "Fire Drill Record" revealed:</p> <ul style="list-style-type: none"> <li>-There was documentation at the top of the record which read "(once a month on each shift)."</li> <li>-Staff initialed the record and documented fire drills as follows: 02/20/15 at 6:00pm, 03/20/15 at 4:00pm, 3/28/15 at 4:00pm, 06/20/15 at 4:00pm, 07/21/15 at 5:00pm, 09/20/15 at 6:00pm, 09/21/15 at 6:00pm, 12/20/15 at 3:00pm, 02/16/16 at 4:00pm, and 06/18/16 at 5:00pm.</li> <li>-There was documentation in the comments section of the record that all residents and staff "made it out."</li> </ul> <p>Review of the Fire Inspection report revealed the last inspection was completed on 01/14/16.</p>	C 100		

Division of Health Service Regulation

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C 100	<p>Continued From page 25</p> <p>Confidential staff interviews revealed: -Staff had not ever observed or participated in a fire drill at the facility. -Fire drills were supposed to be conducted quarterly. -The staff could not provide an explanation as to why the fire drill log was signed as being completed when there had not been any fire drills.</p> <p>Interview with the Administrator on 07/28/16 at 4:30pm revealed the Administrator did not know why residents reported they had not participated in any fire drills; staff documented the fire drills were done.</p> <p>Review of the Plan of Protection submitted by the facility on 07/28/16 revealed: -Facility staff would be responsible for completing fire drills every three months.</p> <p>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED 09/11/16.</p>	C 100		
C 102	<p>10A NCAC 13G .0317 (a) Building Service Equipment</p> <p>10A NCAC 13G .0317 Building Service Equipment</p> <p>(a) The building and all fire safety, electrical, mechanical, and plumbing equipment in a family care home shall be maintained in a safe and operating condition</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p>	C 102		

Division of Health Service Regulation

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C 102	<p>Continued From page 26</p> <p>Based on observation and interview, the facility failed to assure all plumbing equipment in the facility was maintained in a safe and operating condition as related to the water pump providing adequate water for residents' showers. The findings are:</p> <p>Confidential interview with resident on 07/14/16 revealed the resident was concerned because the facility did not have good water pressure.</p> <p>Observation of the water pressure on 07/14/16 during the facility tour revealed the water pressure from the common bathroom sink was normal.</p> <p>Confidential interview with a two residents on 07/18/16 revealed: -The water pressure got low almost every day. -The shower cuts off every day; "we can barely wash." -Residents had gotten stuck with soap in their hair when the water cut off. -"How can we take a shower if it's going to keep cutting off?"</p> <p>Confidential interviews with two residents on 07/21/16 revealed: -The water turned off all the time, about 98% of the time, "they could not shower." -There was only one pump and it was shared with the home in front. -The water will stop running and "we get stuck with soap all over us." -Usually only one resident could take a shower, and the other residents would have to wait. -Then, if the water turned off, the dishes and laundry could not be washed. -The Administrator was aware, because the residents had told her.</p>	C 102		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 102	<p>Continued From page 27</p> <ul style="list-style-type: none"> <li>-The Administrator and the Supervisor-in-Charge (SIC) "don't give a dog."</li> <li>-The Administrator would tell the residents, "You smell musky. You should wash every day."</li> <li>-The Administrator called the residents "disgusting."</li> <li>-The residents couldn't help they were not able to shower.</li> </ul> <p>Telephone interview with a resident's family member on 07/27/16 at 3:16pm revealed:</p> <ul style="list-style-type: none"> <li>-The family was aware there were problems with the water.</li> <li>-The residents could not use the bathroom or take a shower, because the septic tank overflowed.</li> <li>-The residents would walk to a convenience store across the street to use the bathroom.</li> </ul> <p>Telephone interview with the representative of the facility landlord on 07/27/16 at 9:48am revealed:</p> <ul style="list-style-type: none"> <li>-The first time the landlord representative was contacted about the low water pressure was on 07/20/16.</li> <li>-The Administrator called the landlord representative and said "the state is doing an investigation" and the "state" told the Administrator that the landlord would have to put in two separate wells to fix the water pressure.</li> <li>-The landlord representative had sent someone to check the water on the same date she was notified of the problem (07/20/16).</li> <li>-There had been one previous incident "a couple of months ago" when the water would not work at all.</li> <li>-The landlord sent someone to check the water and it was noted that the switch to the well had been turned off.</li> <li>-"The switch had to have been turned off by somebody there."</li> </ul>	C 102		

Division of Health Service Regulation

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C 102	<p>Continued From page 28</p> <p>-The Administrator was responsible for notifying the landlord of any problems; the Landlord could not address problems that were not reported.</p> <p>Interview with the store clerk who works at the nearby convenient store on 07/28/16 at 9:45am revealed:</p> <p>-He worked the morning shift until 1:0)pm. -Residents came from "the home all of the time." -Reports matching the description of Residents #2 and #3 were given that these two residents "came to the store a lot." -A description matching Resident #3 revealed the resident was in the store on the morning of 07/28/16.</p> <p>Confidential interview with a resident on 07/28/16 revealed:</p> <p>-The residents still could not shower or shave. -There was not enough water pressure to wash their hands after using the bathroom.</p> <p>Observation of the water pressure at the residents' bathroom sink on 07/28/16 at 06:38am revealed the water flowed slowly from the faucet when first turned on, increased, then decreased again.</p> <p>Observation of the water pressure in the residents' bathroom on 07/28/16 at 3:40pm revealed the water flowed slowly from the faucet.</p> <p>Observation of Resident #1 on 07/28/16 at 4:05pm revealed the resident took a shower.</p> <p>Observation of Resident #2 on 07/28/16 at 4:35pm revealed Resident #2 went into the bathroom with her clothes to take a shower.</p> <p>Interview with a Resident #2 on 07/28/16 at</p>	C 102		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 102	<p>Continued From page 29</p> <p>5:00pm revealed she had tried to take a shower, but the water cut off in the middle of her shower before she could wash her hair.</p> <p>Observation of Resident #2 on 07/28/16 at 5:00pm revealed that her hair was partially wet in spots at the back of her head; her hair at the front and on the top was dry.</p> <p>Observation of Resident #4 on 07/28/16 at 5:19pm revealed he was trying to get a glass of water from the kitchen sink and the water pressure was a slow trickle.</p> <p>Confidential interview with 2 staff revealed: -The water pressure got low because the facility was on the same well as the house beside it. -The problems with the water started "maybe 6 months ago." -The water stopped "a lot." -Residents got upset about the water problems. -The water pressure got low when residents were taking a shower or doing laundry. -The Administrator was aware of the water problems. -The staff had asked residents to take a shower in the morning instead of the evening.</p> <p>Interview with the Administrator on 07/18/16 at 9:05am revealed: -The Administrator was not aware of the problems with the water; a new pump was put in a few months ago. -Staff acts like everything was good at the facility and "barely notify" her of any concerns. -Staff never called her so she thought everything was "running smooth down here."</p> <p>Interview with the Supervisor in Charge (SIC) on 07/28/16 at 3:40pm revealed:</p>	C 102		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 102	<p>Continued From page 30</p> <ul style="list-style-type: none"> <li>-The water stopped "at times."</li> <li>-The problem had been going on "about a month on so."</li> <li>-The SIC thought both houses on the property used the "same water" which is what caused the problem.</li> <li>-The SIC was aware of only one resident complaining about the water.</li> <li>-The water pressure usually started decreasing around 6:30-7:00pm daily so residents were asked to shower before then.</li> <li>-The Administrator was aware of the problem with the water and had called the Landlord to inquire about the problem.</li> </ul> <p>Interview with the Administrator on 07/28/16 at 6:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator called the realtor company who owned the home last week and told them "the state was here" and the water pump needed fixing.</li> <li>-A maintenance man came to the facility last Wednesday (07/20/16) and replaced the pump.</li> </ul> <p>Review of the Plan of Protection submitted 07/28/16 revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator contacted the Landlord about the water.</li> <li>-A plumber would be at the facility on 07/29/16 to check the water.</li> </ul> <p>THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED 09/11/16.</p>	C 102		
C 112	<p>10A NCAC 13G .0318(a) Outside Premises</p> <p>10A NCAC 13G .0318 Outside Premises (a) The outside grounds of new and existing family care homes shall be maintained in a clean</p>	C 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 112	<p>Continued From page 31 and safe condition.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the outside of the facility was maintained in a clean and safe condition. The findings are:</p> <p>Observation of the outside premises of the facility on 07/14/16 at 6:45am revealed: -There was a tire propped against the side of the house underneath the window. -There were two indoor style chairs sitting to the right of the porch; one chair was missing the seat and had a piece of wood laying on the seat area. -There was a broken light fixture to the right of the door.</p> <p>Observation of the outside premises of the facility on 07/18/16 at 6:50pm revealed: -There were 5 bags of trash sitting in a chair on the side of the house. -There was a tire propped against the side of the house underneath the window.</p> <p>Observation on 07/28/16 at 11:52am revealed: -The white shingles above the air conditioning system were stained with a green and brown colored substance. -There were five bags of trash and two cardboard boxed on the ground on the left side of the steps. -There was a tire propped against the side of the house underneath the window. -There was a pile of debris and trash such as a pieces of wood, pieces of a metal chair, plastic containers, aluminum cans, paper, and fast food disposable drinking cups in a pile in the yard in the right back corner of the property.</p> <p>Observation of the outside of the facility on</p>	C 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 112	<p>Continued From page 32</p> <p>07/28/16 at 2:30pm revealed:</p> <ul style="list-style-type: none"> <li>-A metal chair that was missing the seat was sitting to the right of the porch.</li> <li>-The living room window to the right of the porch had a wire hanging from the top portion of the window.</li> <li>-The front porch ledge had a brick missing.</li> <li>-The front porch railing had green mold along the rails.</li> <li>-There was green mold and dark, black-colored mildew along the bottom portion of the bricks on the front porch and ramp.</li> <li>-The glass in the window at the rear of the facility was shattered; no broken glass seen on the ground.</li> <li>-The grass was thick throughout the entire yard.</li> </ul> <p>Confidential interview with a resident revealed the outside light was broken and had been as long as he could remember.</p> <p>Interview with the Administrator on 07/14/16 at 1:48pm revealed:</p> <ul style="list-style-type: none"> <li>-The facility recently had multiple repairs completed after a construction survey.</li> <li>-The owner of the building was responsible for any repairs in the facility.</li> </ul> <p>Telephone interview with a family member on 07/26/16 at 1:02pm revealed the facility would have trash "piled up" in the laundry room and outside.</p> <p>Telephone interview with the property owner/Landlord's Representative on 07/27/16 at 10:30am revealed upkeep of the outside of the facility grounds was the responsibility of the tenant/Administrator.</p> <p>Telephone interview with a second family member</p>	C 112		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 112	Continued From page 33  on 07/28/16 at 5:30pm revealed the grass was uncut when the family member visited the home on two occasions.  Interview with the Administrator on 07/18/16 at 9:05am revealed: -The Administrator thought the facility was "up to par." -" Last week" a man came to the facility with his family member to look into admitting his family member; the man told the Administrator the " state of the building" was " not up to par" and did not admit his family member.	C 112		
C 133	10A NCAC 13G. 0403(c) Qualifications of Medication Staff  10A NCAC 13G. 0403 Qualifications of Medication Staff (c) Medication aides and staff who directly supervise the administration of medications, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.  This Rule is not met as evidenced by: Based on personnel record review and interview, the facility failed to assure 3 of 3 Medication Aides (MAs) sampled (A, B, and C) completed six hours of continuing education annually related to medication administration.  The findings are:  1. Review of Staff A's personnel record revealed: -Staff A was hired 06/17/14 as a Medication Aide (MA)	C 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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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 133	<p>Continued From page 34</p> <p>-The only documentation of continuing education related to medication administration was from 2014.</p> <p>-There was no documentation of Staff A completing any continuing education in 2015 or 2016.</p> <p>Staff A was not available for interview.</p> <p>Interview with the Administrator on 07/14/16 at 1:25pm revealed Staff A was out on leave at the time of the survey.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <p>2. Review of Staff B's personnel record revealed: -Staff B was hired 01/17/14 as "Direct Care Staff." -There was no documentation of Staff B completing continuing education related to medication administration.</p> <p>Interview with Staff B on 07/14/16 at 8:40am revealed Staff B performed cooking, cleaning, transportation, and Medication Aide (MA) duties, including administering medications in the facility.</p> <p>Interview with Staff B on 07/28/16 at 7:00am revealed Staff B thought she had all the training needed to work as a MA.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <p>3. Review of Staff C's personnel record revealed: -Staff C was hired 09/11/13 as the Supervisor in Charge (SIC). -The only documentation of continuing education was from 2014. -There was no documentation of Staff C</p>	C 133		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 133	<p>Continued From page 35</p> <p>completing any continuing education in 2015 or 2016.</p> <p>Interview with Staff C on 07/14/16 at 1:45pm revealed Staff C thought she was up to date on all of her required training.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <hr/> <p>Interview with the Administrator on 07/14/16 at 1:59pm revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator was responsible for all staff training, credentials, and records.</li> <li>-The Administrator thought all MAs had completed all of the training required to work as a MA.</li> </ul>	C 133		
C 147	<p>10A NCAC 13G .0406(a)(7) Other Staff Qualifications</p> <p>10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall:</p> <p>(7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 3 staff sampled (Staff A, B, And C) had a state wide criminal background screening in accordance with G.S. 131D-40 upon hire.</p> <p>The findings are:</p> <p>1. Review of Staff A's personnel record revealed: -Staff A was hired 06/17/14 as a Medication Aide</p>	C 147		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 147	<p>Continued From page 36</p> <p>(MA)</p> <p>-There was documentation of a county criminal background screening for Staff A completed on 03/03/15.</p> <p>-There was no documentation of a state wide criminal background screening being completed for Staff A upon hire.</p> <p>Staff A was not available for interview.</p> <p>Interview with the Administrator on 07/14/16 at 1:25pm revealed Staff A was out on leave at the time of the survey.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <p>2. Review of Staff B's personnel record revealed: -Staff B was hired 01/17/14 as "Direct Care Staff." -There was no documentation of a state wide criminal background screening in Staff B's record.</p> <p>Interview with Staff B on 07/14/16 at 8:40am revealed Staff B performed cooking, cleaning, transportation, and MA duties in the facility.</p> <p>-Staff B thought she had all of the training and met all of the requirements to work in the facility.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <p>3. Review of Staff C's personnel record revealed: -Staff C was hired 09/11/13 as the Supervisor in Charge (SIC). -There was documentation of a county-wide criminal background screening completed on 08/15/12 for Staff C. -There was no documentation of a state wide criminal background screening in Staff C's</p>	C 147		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 147	Continued From page 37 record.  Interview with Staff C on 07/14/16 at 1:45pm revealed: -Staff C had not had a state criminal background screening. -Staff C thought she only needed a county-wide criminal background screening.  Refer to the interview with the Administrator on 07/14/16 at 1:59pm.  Interview with the Administrator on 07/14/16 at 1:59pm revealed: -The Administrator was responsible for all staff training, credentials, and records. -As far as the Administrator knew, all staff had only the county criminal background screening. -The Administrator was not aware of the requirement for state criminal background screening.	C 147		
C 185	10A NCAC 13G .0601(a) Management and Other Staff  10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 38 Subchapter.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations, interviews and record reviews, the administrator failed to assure the management, policies, and overall operations of the facility were in substantial compliance with the rules and statutes by not being reachable and available to staff, residents and family members, ensuring that at no time residents were left unsupervised at the facility (Resident #4), ensuring there was staff at the facility when the day program transportation arrived to the facility with the residents, and assuring the supervision, health care, medication administration, fire safety and quarterly fire drills, building service equipment, housekeeping and furnishings, and residents' rights, which is the responsibility of the Administrator.</p> <p>The findings are:</p> <p>Confidential staff interviews revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator was hard to get in touch with because she frequently changed her telephone number.</li> <li>-The Administrator would not answer the phone at times.</li> <li>-The Administrator usually came to the facility once each week to bring groceries.</li> <li>-There was only two staff that worked at the facility full time.</li> <li>-It had gotten to a point that staff did not call the Administrator because there was "no use," because the Administrator left everything to the Supervisor-In-Charge (SIC) to do.</li> </ul>	C 185		
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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 39</p> <p>Confidential interview with a resident's family member revealed the family member had a "very hard time" getting in contact with the SIC or the Administrator.</p> <p>Telephone interview with a resident's guardian on 07/26/16 at 1:02pm revealed: -There were multiple occasions when the guardian could not reach the Administrator or SIC by phone. -The Administrator never returned the guardian's calls. -The guardian had not been informed about "so many things" including various incidents that happened involving the resident.</p> <p>Interview with Resident #3 on 07/21/16 at 10:50am revealed: -Resident #3 had not wanted to go to the Psychosocial Rehabilitation (PSR) program and staff locked him out of the facility and left him there alone for the entire day. -Resident #3 did not know the date but thought it was "last week." -The staff told Resident #3 she had to check on her kids and left. -It was hot outside that day but he walked to the store and got a drink, because he did not have any food or water with him. -Resident #3 "got worried" the day staff locked him out.</p> <p>Review of Resident #3's current FL-2 dated 06/08/16 revealed diagnoses included schizophrenia, depression, hypertension, and type 2 diabetes.</p> <p>Review of Resident #3's Assessment and Care Plan revealed Resident #3 had a history of wandering, mental illness, and was</p>	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 40</p> <p>forgetful-"needs reminders."</p> <p>Review of the "Consumer Sign-In Sheet" from the PSR program revealed the only date Resident #3 did not sign in at the PSR program during the month of July 2016 was 07/05/16.</p> <p>Interview with the clerk at the store on 7/28/16 at 9:45am: -The clerk described an individual of Resident #3's description coming in to the store to purchase cigarettes, food, and drinks; the clerk had not had any problems with Resident #3. -Somebody at the facility called and told clerk not to sale the residents certain stuff and he told her that it was not his job to monitor what they buy.</p> <p>Telephone interview with the SIC on 7/18/16 at 4:35pm revealed: -The day program transported the residents to and from the facility. -The residents usually came back in the afternoon around 3:00pm. -If the SIC was going to be late, she would call the day program staff and let them know. -There had been times when someone was not at the facility when the day program's van arrived with the residents, but it was rare.</p> <p>Interview with Resident #1 on 7/21/16 at 9:17am revealed: -It happened a lot that when the van driver dropped the residents off, they would have to wait thirty minutes for a staff to come to the facility. -The residents sat in the van and waited until the staff came to the facility. -Sometimes, the residents would be taken to another facility that was not far away, and dropped off.</p>	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 41</p> <p>Interview with Resident #2 on 7/21/16 at 11:18am revealed:</p> <ul style="list-style-type: none"> <li>-There had been times when the SIC would not be at the facility when the van dropped us off from the day program.</li> <li>-The van driver would get upset because no staff would be at the facility.</li> <li>-Resident #2 was not able to recall how long the van driver would have to wait because she "could not tell time."</li> </ul> <p>Interview with the transportation driver of the day program on 07/21/16 at 08:50am revealed:</p> <ul style="list-style-type: none"> <li>-The day program closed at 2:30pm daily and normal drop off time for the residents at the facility was between 3:15pm-3:30pm.</li> <li>-Over the last 3 months, there had been "a lot" of problems with staff not being at the facility when he dropped the residents off.</li> <li>-It was not right to leave the residents there alone or make them wait.</li> <li>-There had been multiple incidents when they had to wait 45 minutes to one hour for staff to arrive at the facility.</li> <li>-Residents did not like having to wait on the staff to get to the facility: Resident #2 "got irritated" when they had to wait on staff.</li> <li>-If staff was not at the facility when they got there, the procedure was to call the staff to let them know they were there waiting, but you could not get staff (the SIC) to answer the telephone either.</li> <li>-From one day to the next, the driver did not know where to drop the residents off.</li> <li>-"They are not doing right at [facility location]."</li> </ul> <p>Review of the day program Transportation Report for May-July 2016 revealed:</p> <ul style="list-style-type: none"> <li>-"On two occasions" in May 2016, the SIC called the day program and asked to keep the residents at the day program facility, stating she would pick</li> </ul>	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 22</p> <p>them up. "On both occasion our staff remained for approximately an hour" for residents to be picked up.</p> <p>-On 05/27/16, the driver arrived at the facility at 3:15pm with the residents; there were no staff present at the facility." Driver waited at facility until 5:30pm" then returned the residents to the day program facility; Facility staff picked the residents up from the day program facility at "approximately 6:00pm."</p> <p>-06/16/16, driver arrived at facility 3:15pm; staff did not arrive until 3:35pm.</p> <p>-"In the month of June (2016), there were other staff delays of 15-20 minutes; however, driver did not denote the exact day and time."</p> <p>-07/11/16 and 07/12/16, driver arrived at facility at 3:15pm; staff arrived at 4:00pm.</p> <p>Review of correspondence mailed to the Administrator dated 07/13/15 from the Executive Director of the PSR (psychosocial rehabilitation) day program revealed:</p> <p>-"It has come to our attention that there are several incidents of your staff not being present at your group home when we transport your consumers there in the afternoons."</p> <p>-"We offer transportation to and from our PSR facility as a courtesy to our consumers."</p> <p>- " It is imperative that a staff be present at your facility when our drivers arrive so they can continue to provide transportation for the consumers."</p> <p>-"If these incidents continue, we will suspend transportation for your consumers."</p> <p>Interview with the Executive Director of the day program on 07/14/16 at 10:08am revealed:</p> <p>-There had been multiple incidents when residents had been transported to the facility from the day program when no staff would be present</p>	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 43</p> <p>at the facility.</p> <ul style="list-style-type: none"> <li>-The residents could not be left there alone without staff present.</li> <li>-The residents in the home were at risk of losing their transportation service to the program.</li> <li>-The SIC and Administrator had been notified of the issue.</li> <li>-The Administrator said the SIC was responsible for assuring staff were at the facility when residents were dropped off.</li> </ul> <p>Interview with the Administrator on 07/14/16 at 12:45pm revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator was aware of two incidents when staff were not at the facility when residents were dropped off from the day program.</li> <li>-One day, about 4 months ago, staff was late due to a flat tire; the van had to wait on the staff to arrive at the facility.</li> <li>-The Administrator did not know the date of the second incident which occurred when the SIC and another staff switched work schedules and there was some confusion; the staff arrived "within 15 minutes" after the PSR program called.</li> </ul> <p>Additional noncompliance identified during the survey included the following rules areas:</p> <ol style="list-style-type: none"> <li>1. Based on observations and interviews, the facility failed to assure the walls were clean and in good repair in 3 of 3 resident bedrooms, the common resident bathroom, living room and hallway, and the ceiling was in clean and in good repair in the living room and bathroom, and the floors were clean and in good repair in the 2 of 3 resident bedrooms, the common bathroom, and the kitchen. [Refer to Tag C0074 10A NCAC 13G. 0315(a)(1) Housekeeping and Furnishings (TYPE B VIOLATION)].</li> </ol>	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 44</p> <p>2. Based on observations and interviews, the facility failed to assure the facility bathroom, kitchen, living room, 3 of 3 resident bedrooms, and outside grounds were kept clean, uncluttered, and free of hazards. [Refer to Tag C0078 10A NCAC 13G. 0315(a)(5) Housekeeping and Furnishings (TYPE B VIOLATION)].</p> <p>3. Based on interviews, record reviews, and observations, the facility failed to replace the batteries in one smoke detector in order to maintain a working fire alarm system. [Refer to Tag C0097 10A NCAC 13G. 0316(b) Fire Safety and Disaster Plan (TYPE B VIOLATION)].</p> <p>4. Based on observations, record reviews, and interviews, the facility failed to assure fire drills were completed quarterly in 2015 and 2016. [Refer to Tag C0100 10A NCAC 13G. 0316(e) Fire Safety and Disaster Plan (TYPE B VIOLATION)].</p> <p>5. Based on observation and interview, the facility failed to assure all plumbing equipment in the facility was maintained in a safe and operating condition as related to the water pump providing adequate water for residents' showers. [Refer to Tag C0102 10A NCAC 13G. 0317(a) Building Service Equipment (TYPE B VIOLATION)].</p> <p>6. Based on record reviews and interviews, the facility failed to assure that 4 of 6 residents sampled (#1, #2, #4, #5) went to appointments with their medical and mental health providers resulting in Resident #1 developing infection from a surgical procedure; and, failed to notify the health care provider or seek emergency treatment for 3 of 6 residents sampled (#1, #2, #3) who had requested physician visits for pain</p>	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 45</p> <p>(#1) and allegations of being raped (#2) and who had refused blood pressure medication (#3). [Refer to Tag C0246 10A NCAC 13G. 0902(b) Health Care (TYPE A1 VIOLATION)].</p> <p>7. Based on observations, interviews, and record reviews, the facility failed to assure the provision of transportation for the residents to and from the hospital, emergency room, medical appointments, and the day program for all the residents who resided in the facility. [Refer to Tag C0296 10A NCAC 13G. 0906(a) Other Resident Services (TYPE B VIOLATION)].</p> <p>8. Based on observations and interviews the facility failed to assure 4 of 4 residents sampled (#1, #2, #3, #4) were treated with respect, consideration and dignity as evidenced by not allowing residents to have a second helping at meals, not allowing residents the choice of attending a psychosocial rehabilitation (PSR) program, staff talking to residents in a disrespectful manner, locking one resident (#3) out of the facility, and not allowing one resident (#4) to attend outings. [Refer to Tag C0311 10A NCAC 13G. 0909 Residents' Rights (TYPE B VIOLATION)].</p> <p>9. Based on record reviews and interviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 residents sampled (#1, #2, #3) including errors with oral antidiabetic medications (#1, #2), antibiotics (#1, #2), antipsychotics (#1, #2), an antiulcer (#2), a pain medication (#1), an anti-anxiety medication (#1), a probiotic, and gastroesophageal reflux medication (#3) resulting in residents going without medications for</p>	C 185		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 185	<p>Continued From page 46</p> <p>several days. [Refer to Tag C330 10A NCAC 13G. .1004(a) Medication Administration (TYPE A1 VIOLATION)].</p> <p>The administrator failed to ensure staff were at the facility when residents returned from day programs or when a resident did not attend a program resulting in Resident #3 being left unsupervised at the facility because Resident #3 did not wish to attend the day program, and residents having to wait extended periods outside for staff to return to the facility. Resident #3 was locked out of the facility and left to wander away from the home with no water or food. The staff, SIC, and Administrator failed to ensure that staff were at the facility when the driver for the day program brought the residents back to the facility. On several occasions, the driver had to wait with the residents at the facility until staff arrived which caused the residents to become upset. The administrator failed to ensure residents were free of neglect and received appropriate care services in accordance with orders, care plans and assessed needs in the areas of health care and medications. Substantial noncompliance was identified in additional rule areas which included implementation of Residents Rights, housekeeping and furnishings, fire safety, and building service equipment. The failure of the Administrator to take responsibility for managing the facility to ensure compliance of the rules of the Division of Health Service Regulation, as well as Resident Rights, constitutes a Type A1 Violation for serious neglect and serious physical harm.</p> <p>Review of the Plan of Protection submitted 07/28/16 revealed: -The Administrator will make sure the facility is</p>	C 185		

Division of Health Service Regulation

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C 185	Continued From page 47  operated correctly. -The Administrator will be available by phone 24 hours and will increase her visits to once a week. -The Administrator will monitor staff on a weekly basis to make sure all staff is doing their job correctly and will hold meetings once a month of the overall facility.  THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 08/27/16.	C 185		
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: A1 VIOLATION  Based on record reviews and interviews, the facility failed to assure that 4 of 6 residents sampled (#1, #2, #4, #5) went to appointments with their medical and mental health providers resulting in Resident #1 developing infection from a surgical procedure; and, failed to notify the health care provider or seek emergency treatment for 3 of 6 residents sampled (#1, #2, #3) who had requested physician visits for pain (#1) and allegations of being raped (#2) and who had refused blood pressure medication (#3). The findings are:  1. Review of Resident #1's current FL2 dated 11/23/15 revealed: -Diagnoses included major depressive disorder, hypertension, diabetes, chronic obstructive	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 48</p> <p>pulmonary disease, and hepatitis C. -Resident #1 was documented as being injurious to self. -He was ambulatory and continent of bowel and bladder.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 11/13/15.</p> <p>Review of the assessment and care plan for Resident #1 revealed: -Resident #1 was independent with all activities of daily living. -He had a documented history of mental illness and being injurious to self, and was receiving mental health services.</p> <p>a. Review of a local hospital Emergency Department (ED) encounter for Resident #1 dated 04/17/16 revealed: -The chief complaint was documented as a simple abscess to right axillary for one week with drainage noted. -There was pain, swelling, and redness associated with the abscess. -An incision and drainage procedure was performed to the right axilla to remove 5ml of pus; the area was packed with quarter-inch plain packing. -There was no follow-up instructions for Resident #1 to make an appointment with his primary care provider (PCP).</p> <p>Interview with Resident #1 on 07/14/16 at 07:12am revealed: -Resident #1 had missed 3 doctor appointments "recently". -He missed two appointments at his "family doctor" for a "cyst" under his arm -When Resident #1 saw the Physician Assistant</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 246	<p>Continued From page 49</p> <p>(PA) about the cyst, the PA had to "squeeze it" and it had to be treated with antibiotics." -The cyst "hurt bad" and was oozing for a while.</p> <p>Review of a Patient Chart Report from the Primary Care Physician's (PCP) office dated 04/26/16 revealed: -Resident #1 was seen for a right axillary wound that was drained at the ED on 04/17/16. -The packing that was placed in the ED had not been removed. -Resident #1 reported to the PA that he had been asking the staff at the facility to bring him to the PCP ' s office for a recheck because there was continued drainage from the wound. -Upon examination, a moderate amount of thick, purulent drainage was noted. -A wound culture was obtained that was positive for staphylococcus aureus (a gram positive bacteria frequently found on the skin). -Resident #1 was prescribed Clindamycin (an antibiotic) and was to follow-up in two days.</p> <p>Review of a second Patient Chart Report from the PCP's office dated 04/28/16 revealed: -Resident #1 saw the PA for a recheck of the right axilla wound. -The resident had not started the antibiotic as of 04/28/16, because the group home had not gotten the antibiotic. -The PA documented that the caregiver did not fax the prescription to the pharmacy for the antibiotic, so the antibiotic had not been started yet. The PA made the caregiver who accompanied Resident #1 aware that the antibiotic was "to start TODAY with no exceptions." -Upon examination, the PA noted that the abscess had a minimal amount of purulent drainage. Half inch packing was reinserted and</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 50</p> <p>covered with a bandage.</p> <ul style="list-style-type: none"> <li>-Resident #1 was administered Rocephin (an antibiotic) intramuscularly at the PA's office.</li> <li>-The PA scheduled a follow-up appointment on Tuesday, 05/03/16 to recheck the wound.</li> </ul> <p>Telephone interview with the PA on 07/18/16 at 1:55pm revealed:</p> <ul style="list-style-type: none"> <li>-The PA evaluated Resident #1 in the office on 04/26/16 for an abscess wound under his arm; the "wound" had pus coming out of it and was red.</li> <li>-The abscess had been drained and packed in the ED 7 days prior (04/17/16).</li> <li>-The abscess still had the original packing in it from the ED visit.</li> <li>-Resident #1 told the PA he had asked the facility to bring him in sooner for follow up.</li> <li>-The PA had to re-open the abscess and he prescribed antibiotics for Resident #1 on 04/26/16.</li> <li>-When Resident #1 came to the follow up appointment on 04/28/16, he had not been started on the antibiotics prescribed by the PA on 04/26/16.</li> <li>-The PA told the "caregiver" (facility staff) that Resident #1 was to start the antibiotics that day (04/28/16), "no exceptions."</li> <li>-Resident #1 was scheduled for a follow up appointment on 05/03/16. Resident #1 did not come to the appointment on 05/03/16.</li> <li>-The PA evaluated Resident #1 again on 05/11/16 and the wound was healing.</li> </ul> <p>Review of the Appointment History for Resident #1 at the PCP's office revealed Resident #1 was a "no show" for the scheduled 05/03/16 appointment.</p> <p>Interview with the Administrator on 07/18/16 at</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 51</p> <p>9:05am revealed: -Resident #1 had a cyst under his arm and went to the ED "a couple months ago." -Resident #1 had not missed any medical appointments related to the cyst under his arm.</p> <p>b. Review of an ED encounter for Resident #1 dated 01/24/16 revealed: -Resident #1 was treated for urinary retention. -He was to follow up with urology in 2 days.</p> <p>Review of the resident's physician progress notes revealed there were no notes from a urology follow-up within in two days.</p> <p>Telephone interview with a representative from the urology office on 07/14/16 at 2:35pm revealed: -There was no appointment scheduled for Resident #1 during the month of January. -The first time Resident #1 was seen in the urology office was on 02/10/16 for an initial patient visit. -Resident #1 was to follow-up with the urologist on 02/24/16 at 11:00am, but the resident was a "no show."</p> <p>c. Review of an ED encounter for Resident #1 dated 05/20/16 revealed: -The chief complaint was chronic back pain. -Resident #1 was to follow-up with the PCP in two days.</p> <p>Review of the resident's physician progress notes revealed Resident #1 did not follow-up with the PCP on 05/26/16 as scheduled from the ED visit due to the appointment was cancelled by the facility.</p> <p>d. Review of an ED encounter for Resident #1</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 52</p> <p>dated 06/29/16 revealed: -The chief complaint was documented as " retaining urine and only urinating very small amounts " since Sunday, 06/26/16. -A bedside ultrasound was completed and confirmed significant urinary retention. -An indwelling urinary catheter was placed. -A urology follow-up appointment was scheduled (no date indicated), and the ED physician "reiterated plan for follow-up with urology and importance of urology follow-up."</p> <p>Telephone interview with a representative from the urology office on 07/14/16 at 2:35pm revealed: -Resident #1 was scheduled for an ED follow-up on 07/14/16, but was a " no show. " -A staff person from the facility called around 1:00pm on 07/14/16, and rescheduled the appointment for Monday, 7/18/16, "because the state was in the facility."</p> <p>Interview with the SIC on 07/14/16 at 10:40am revealed: -Resident #1 had an appointment at "Urology in [named town]" that day (07/14/16) at 10:00am but the Administrator had to cancel the appointment because the SIC was supposed to take Resident #1 to the appointment but could not take him because she "was here with the state." -The urology appointment on 07/14/16 was the only medical appointment Resident #1 had missed. -Resident #1's urology appointment would be rescheduled.</p> <p>Interview with the Administrator on 07/14/16 at 12:45pm revealed: -Resident #1 had an appointment with the PAC "yesterday" (07/13/16) that had to be cancelled</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 53</p> <p>and rescheduled because of an "emergency." -The Administrator had not cancelled any urology appointments for Resident #1. -There was a "mix up" about Resident #1's urology appointment on 07/14/16 because the SIC "did not have a car this morning." -The SIC called "just now" to re-schedule Resident #1's urology appointment.</p> <p>Interview with the Administrator on 07/18/16 at 09:05am revealed: -Resident #1 had a catheter but the Administrator did not know when or where he got it; Resident #1 also had a catheter before "months ago." -The SIC told the Administrator that Resident #1 removed his catheter on 07/16/16. -Resident #1 did not go to the ED after he pulled out the catheter. -Resident #1 did not want to go to the ED. -Resident #1 should have gone to the ED but the Administrator was told Resident #1 was only bleeding "specks of blood" and he had a doctor's appointment scheduled for 07/18/16 anyway.</p> <p>Interview with the SIC on 7/18/16 at 12:00pm revealed: -She had taken Resident #1 to the urologist's office on 07/18/16. -The doctor told Resident #1 to do in-and-out catheterizations; the doctor showed Resident #1 how to do them. -Resident #1 was given a medication to "make him urinate."</p> <p>Telephone interview with the nurse at the urologist's office on 07/27/16 at 3:54pm revealed: -Resident #1 came to the office on 07/18/16. -No follow-up appointment was scheduled. -The urologist showed Resident #1 and the staff person accompanying him from the home how to</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 246	<p>Continued From page 54</p> <p>" straight cath " [perform in-and-out catheterization]. -The straight catheterization was to be done when needed if the volume in the bladder was greater than 600ml.</p> <p>e. Review of the Appointment History for Resident #1 at the PCP's office revealed: -Resident #1 had an appointment on 01/07/16 with the PCP, but the appointment was cancelled by the facility. -He had appointments on 03/02/16 and 03/29/16 with the PCP and the resident was a "no show." -On 07/13/16, Resident #1 was to follow up with his PCP and was a "no show." -No further appointments had been scheduled.</p> <p>Review of documentation provided by the behavioral health services office revealed: -Resident #1 was a "no show" for an appointment on 10/21/15. -The resident had not seen the provider since the appointment that was missed on 10/21/15.</p> <p>Interview was attempted with the mental health provider on 7/28/16 at 8:50am, but the receptionist stated the provider was out of town until 8/3/16 and the provider on duty had not seen Resident #1.</p> <p>Confidential interview with a staff member revealed: -Resident #1 had missed "several" doctor appointments, but the staff was not sure of the dates of the missed appointments. -The SIC was responsible for making all of the residents' doctors ' appointments. -The SIC was responsible for transporting residents to their doctors ' appointments. -"Last week" the SIC told Resident #1 he had an</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 55</p> <p>appointment and she would pick him up from PSR, but "I think something happened" and the SIC had to deal with it " and could not take Resident #1.</p> <p>Confidential interview with a second staff member revealed: -The staff had heard Resident #1 say he had missed some medical appointments over the past "month or two" but the staff did not know if he had actually missed any appointments. -The SIC was responsible for all residents ' doctors ' appointments and would know if Resident #1 had missed any medical appointments.</p> <p>Confidential interview with a third staff member revealed: -The Administrator took over making all appointments for the residents. -That was why the residents were missing their appointments.</p> <p>2. Review of Resident #2's current FL2 dated 5/2/16 revealed diagnoses included schizoaffective disorder, intellectual disability-moderate, dyspepsia, diabetes mellitus type 2.</p> <p>Review of Resident #2's Resident Register revealed an admission date of 11/20/15.</p> <p>Review of the assessment and care for Resident #2 dated 12/2/15 revealed Resident #2 required supervision for personal hygiene and bathing.</p> <p>a. Review of an incident report dated 05/12/16 revealed: -Resident #2 called the mental health clinic</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 56</p> <p>without the staff at the facility's knowledge, and reported being "raped" by Resident #5 "a month ago." -The mental health clinic called 911 and a detective went to the facility and took reports from Resident #2 and #5.</p> <p>Interview with a staff member at the day program on 07/28/16 at 12:15pm revealed: -On 05/12/16, Resident #2 was reporting hearing voices and having a vaginal discharge and odor. -The staff at the day program called the SIC and encouraged the SIC to make an appointment with Resident #2's physician.</p> <p>Review of a Patient Chart Report from Resident #2's primary provider dated 05/13/16 revealed: -Resident #2 complained of vaginal burning and thick discharge for the past 4 weeks. -The resident was having trouble with details and time, but reported being raped "about a month ago." -The SIC accompanied the resident to the appointment and explained to the provider that Resident #2 and #5 had been "hanging out together a lot off the premises ... police had been notified .... " The SIC planned to separate the 2 residents. -Laboratory results were positive for vaginal bacteria and candida (a yeast or fungal infection). -Resident #2 was prescribed Diflucan (a antifungal) for three days and Flagyl (antibiotic) for seven days. -She was to follow-up in three weeks.</p> <p>Interview with Resident #2 on 7/21/16 at 11:18am revealed: -"[Resident #5's name] raped me. He raped me a bunch of times." -Resident #2 tried to file a police report.</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 246	<p>Continued From page 57</p> <ul style="list-style-type: none"> <li>-The police questioned Resident #2, but the police wanted to know what time it happened and the resident, " can ' t tell time."</li> <li>-Resident #2 wanted to go to the emergency room to see if she was pregnant, but the staff on duty would not let her go.</li> <li>-Resident #2 told the staff about being raped.</li> </ul> <p>Interview with the Administrator on 7/28/16 at 4:40pm revealed:</p> <ul style="list-style-type: none"> <li>-It was approximately 4-5 months ago that Resident #2 told "us."</li> <li>-Resident #2 would get mad if Resident #5 signed out, because Resident #5 was seeing another girl who lived nearby.</li> <li>-The Administrator talked to Resident #5, and Resident #5 told her that he and Resident #2 signed out and went to the woods in January.</li> <li>-Resident #2 would call the mobile crisis staff about the same incident in the woods.</li> <li>-The day program staff was concerned, but "I told them that Resident #5 won't raping Resident #2 because he was gone to [another town.]"</li> <li>-"We were going to separate Resident #2 and #5, but Resident #5 went to the hospital, and was then discharged home to live with his family. Review of the "Patient Chart Report" from Resident #2's primary provider dated 6/27/16 revealed:</li> <li>-Resident #2 reported that she was raped multiple times by another "group home member" and had been having vaginal burning and discharge.</li> <li>-A urine culture was obtained and the result was positive for bacteria.</li> <li>-The resident was prescribed Macrobid (an antibiotic) for seven days and was to follow up in one week.</li> </ul> <p>Telephone interview with Resident #2's Physician</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 58</p> <p>Assistant (PA) on 7/18/16 at 1:55pm revealed: -Resident #2 was evaluated by another provider in the PA's office on 05/13/16 for vaginal discharge and burning and told that provider that she had been raped by another resident one month ago. -Resident #2 was evaluated by the PA for follow up on 06/27/16 at which time Resident #2, again, told the PA she was "raped multiple times" by another resident over a period of months.</p> <p>b. Review of documentation provided by the behavioral health services office on 07/28/16 revealed: -Resident #2's initial mental health evaluation was scheduled on 12/10/15, but the appointment was rescheduled by the provider for 12/30/15. -She saw the mental health provider on 12/30/15. -Resident #2 was a "no show" on 02/24/16 and had another appointment on 03/23/16 that was rescheduled by the facility. -Resident #2 saw the mental health provider on 04/05/16 and not again until 06/29/16.</p> <p>Attempted interview on 07/28/16 with the mental health provider revealed the provider was out of town until 08/03/16, and the provider on duty had not seen Resident #2 before.</p> <p>Review of the Appointment History from Resident #2's PCP revealed: -Resident #2 was a "no show" on 03/02/16. -She had an appointment on 03/17/16, but the appointment was cancelled by the facility.</p> <p>Interview with the SIC on 07/14/16 at 10:40am revealed Resident #2 had not missed any medical appointments.</p> <p>Interview with the Administrator on 07/14/16 at</p>	C 246		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 246	<p>Continued From page 59</p> <p>12:45pm revealed: -The Administrator would get "a plan in place" to assure medical appointments were made by either herself (the Administrator) or the SIC and residents got transported to their appointments. -Resident #2 had an appointment with the PA on 07/13/16 that had to be rescheduled because of an "emergency."</p> <p>3. Review of Resident #3's current FL-2 dated 06/08/16 revealed: -Diagnoses included schizophrenia, depression, hypertension, and type 2 diabetes. -Resident #3 was intermittently disoriented. -The admission date to the facility was documented as 04/13/16. -There was a medication order for Lisinopril 10mg daily. (Lisinopril is a medication used to treat elevated blood pressure).</p> <p>Review of Resident #3's June Medication Administration Records (MARs) revealed: -There was a handwritten entry for Lisinopril 10mg daily with an administration time of 08:00am. -There was documentation on the back of the MARs that Resident #3 "refused" Lisinopril 11 times from 06/09/16-06/16/16 and 06/18/16-06/20/16.</p> <p>Review of Resident #3's July MARs on 07/14/16 revealed: -There was a preprinted entry for Lisinopril 10mg daily with an administration time of 08:00am. - There was documentation on the back of the MARs that Resident #3 "refused" Lisinopril 4 times from 07/09/16-07/12/16.</p> <p>Review of Resident #3's care notes and MARs revealed there was no documentation of the</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 60</p> <p>prescribing provider being notified of Resident #3's refusals.</p> <p>Interview with Resident #3 on 07/21/16 at 10:50am revealed: -Resident #3 stopped taking his blood pressure medication (Lisinopril). -The medication made Resident #3 feel funny. -Resident #3 did not know if his doctor was aware he was not taking his Lisinopril.</p> <p>Interview with a staff member on 07/14/16 at 08:40am revealed: -Resident #3 refused his Lisinopril "every day." -Resident #3 said the Lisinopril was not his pill and it does not work; "he won't take it." -The staff had not notified the provider about Resident #3's refusal. -The staff notified the SIC about Resident #3 refusing Lisinopril; "[SIC's name} handles all that."</p> <p>Telephone interview with the Registered Nurse (RN) at Resident #3's Physician Assistant's (PAC) office revealed: -The facility had not notified the office about Resident #3 refusing any medications. -The PAC office expected to be notified of medication refusals.</p> <p>Telephone interview with Resident #3's PAC on 07/21/16 at 1:55pm revealed: -The PAC had no recollection of being notified Resident #3 was refusing Lisinopril. -The PAC last evaluated Resident #3 in the office on 06/08/16. -Resident #3's blood pressure was 172/90 mm/Hg on 06/08/16; the PAC recalled that Resident #3's blood pressure was higher than it had been previously. -The PAC expected Resident #3 to take the</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 61</p> <p>Lisinopril as ordered or to be notified by the facility if he refused the medication.</p> <p>4. Review of Resident #4's current FL-2 dated 07/18/16 revealed diagnoses included schizophrenia, depression, diabetes, hyperlipidemia, and gastroesophageal reflux disease (GERD).</p> <p>Review of the Resident Register revealed Resident #4 was admitted to the facility on 02/09/14.</p> <p>Interview with Resident #4 on 07/14/16 at 7:01am revealed Resident #4 had a colostomy for "4 or 6 months" and "recently" had surgery to reverse the colostomy.</p> <p>Review of the hospital discharge summaries dated 06/09/16 revealed Resident #4 was admitted on 06/02/16 for a surgery to reverse his colostomy discharged on 06/09/16.</p> <p>Review of the Patient Chart Report for Resident #4 revealed Resident #4 was a "no show" for a "hospital follow-up" appointment with the Physician 's Assistant (PA) on 06/15/16 at 10:30am.</p> <p>Interview with Resident #4 on 07/21/16 at 9:42am revealed he had missed medical appointments, because staff had "something else to do."</p> <p>Confidential resident interview revealed the SIC and Administrator "cancel our appointments because they don't want to take us."</p> <p>Interview with the SIC on 07/14/16 at 10:40am revealed Resident #4 had not missed any</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 62</p> <p>medical appointments.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>5. Review of Resident #5's FL-2 dated 05/16/16 revealed: -Diagnoses included bipolar disorder, Tourette's syndrome, and autism spectrum disorder. -The recommended level of care was documented as family care home. -The admission date to the current location was not documented.</p> <p>Review of medical records obtained from the mental health provider revealed: -Resident #5 was scheduled a follow-up appointment for a post-hospital visit on 5/6/16 at 3:20pm and was a "no show." -Resident #5 had appointments on 10/9/15, 7/15/15, and 5/26/15 and was a "no show" for all three appointments.</p> <p>Resident #5 was not available for interview.</p> <p>Resident #5's physician was not available for interview.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <hr/> <p>Interview with the Administrator on 07/14/16 at 12:45pm revealed: -The SIC or Administrator were responsible for scheduling resident appointments and transporting residents to appointments. -The SIC was responsible for appointments in the county in which the facility was located; the Administrator was responsible for appointments in a neighboring county.</p>	C 246		

Division of Health Service Regulation

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C 246	<p>Continued From page 63</p> <p>-The Administrator would get a plan in place to assure residents' appointments were scheduled as directed and residents were transported to their appointments.</p> <p>The facility's failure to assure residents received appropriate health care, by not notifying the physician when Resident #1 complained of pain at a surgical site, resulting in delayed assessment and treatment of infection at the surgical site requiring an additional invasive procedure and by not notifying the physician when Resident #2 complained of being raped by another resident resulting in the resident ' s hearing voices and delayed treatment of vaginal infections. This constitutes a TYPE A1 VIOLATION for serious harm and neglect.</p> <p>Review of the Plan of Protection submitted by the facility on 07/28/16 revealed: -The SIC would assure all residents were transported to all appointments as directed by their health care providers. -If the SIC cannot transport a resident to a health care appointment, the SIC would notify the Administrator to take the resident to the appointment. -The SIC and Administrator would start working together to assure residents went to health care appointments.</p> <p>THE CORRECTION DATE OF THIS TYPE A1 VIOLATION SHALL NOT EXCEED 08/27/16.</p>	C 246		
C 247	<p>10A NCAC 13G .0902(c) Health Care</p> <p>10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:</p>	C 247		

Division of Health Service Regulation

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C 247	<p>Continued From page 64</p> <p>(1) facility contacts with the resident's physician, physician service, other licensed health professional, including mental health professional, when illnesses or accidents occur and any other facility contacts with a physician or licensed health professional regarding resident care;</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure documentation of facility contacts with the residents' physicians, including mental health professionals, regarding resident care was maintained in the residents' records for 3 of 4 sampled residents (#1, #2, #4).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 11/23/15 revealed diagnoses included major depressive disorder, hypertension, diabetes, chronic obstructive pulmonary disease, and hepatitis C.</p> <p>Review of staff communication notes revealed: -There was no communication notes regarding any contacts with the primary care provider (PCP) for resident complaints and changes in Resident #1's condition that required emergency room visits, such as complaints of back pain, urinary retention, or tremors. -There was no documentation related to foley catheter care that the resident received in the emergency room on 6/29/16. -There was no documentation in the notes of Resident #1's appointments with the PCP or the</p>	C 247		

Division of Health Service Regulation

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C 247	<p>Continued From page 65</p> <p>mental health provider.</p> <p>Interview with a staff on 7/14/16 at 8:10am revealed she did not know when Resident #1 received the foley catheter.</p> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>Refer to interview with the Administrator on 07/18/16 at 9:05am.</p> <p>2. Review of Resident #2's current FL2 dated 5/2/16 revealed diagnoses included schizoaffective disorder, intellectual disability-moderate, dyspepsia, diabetes mellitus type 2.</p> <p>Review of staff communication notes revealed: -There was no communication notes regarding any contacts with the primary care provider (PCP) for resident complaints and changes in Resident #2's condition that required emergency room visits, such as complaints of hallucinations, anxiety, and vaginal discharge. -There was no documentation in the notes of Resident #2's appointments with the PCP or the mental health provider.</p> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>Refer to interview with the Administrator on 07/18/16 at 9:05am.</p> <p>3. Review of Resident #4's current FL-2 dated 07/18/16 revealed diagnoses included schizophrenia, depression, diabetes,</p>	C 247		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 247	<p>Continued From page 66</p> <p>hyperlipidemia, and gastroesophageal reflux disease (GERD).</p> <p>Interview with Resident #4 on 07/14/16 at 7:01am revealed Resident #4 had a colostomy for "4 or 6 months" and "recently" had surgery to reverse the colostomy.</p> <p>Confidential staff interviews revealed:                      -Resident #4 stuck an ink pen up his rectum causing him to have surgery and the colostomy.                      -Resident #4 had problems with the colostomy bag leaking and busting.                      -A home health (HH) RN came to the facility to assist Resident #4 with the colostomy when he had it.                      -Resident #4 did not have the colostomy any more.                      -Staff did not know why information was not in the resident records related to their hospital and emergency room visits; "It should be in there so we know what to do."                      -"[SICs name] handles all that and we ain't supposed to mess with it."</p> <p>Review of Resident #4's record revealed there was no documentation in the record related to Resident #4's trauma, hospitalizations, or surgeries resulting in colostomy or the colostomy reversal, problems with the colostomy leaking, or HH visits.</p> <p>Telephone interview with Resident #4's psychiatrist on 07/18/16 at 12:50pm revealed:                      -Resident #4 stuck an ink pen up his rectum "as a sexual thing" and punctured his colon.                      -There should documentation maintained in Resident #4's record related to the incident with the ink pen.                      -The psychiatrist wanted to know how or if staff</p>	C 247		

Division of Health Service Regulation

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C 247	<p>Continued From page 67</p> <p>would know how to respond if there was a problem without any documentation in the record.</p> <p>Refer to interview with the Supervisor-in-Charge (SIC) on 07/18/16 at 12:00pm.</p> <p>Refer to interview with the Administrator on 07/18/16 at 9:05am.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 07/18/16 at 12:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The SIC kept the paper work, orders, and progress notes from medical appointments in her car in a notebook.</li> <li>-She kept the information in her notebook until she could get back from the appointments and go to another facility to fax the orders to the pharmacy.</li> </ul> <p>Interview with the Administrator on 07/18/16 at 9:05am revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator did not know why the documentation was not kept in the records.</li> <li>-The SIC told her all orders were in the records.</li> </ul>	C 247		
C 249	<p>10A NCAC 13G .0902(c)(3)(4) Health Care</p> <p>10A NCAC 13G .0902 Health Care</p> <p>(c) The facility shall assure documentation of the following in the resident's record:</p> <p>(3) written procedures, treatments or orders from a physician or other licensed health professional; and</p> <p>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record</p>	C 249		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 249	<p>Continued From page 68</p> <p>reviews, the facility failed to assure documentation of written treatments and orders from a licensed health professional and implementation of treatments and orders were maintained in the residents' records for 3 of 4 sampled residents (#1, #2, #4).</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>Review of Resident #1's current FL2 dated 11/23/15 revealed diagnoses included major depressive disorder, hypertension, diabetes, chronic obstructive pulmonary disease, and hepatitis C.</li> </ol> <p>Review of physician orders provided by the pharmacy on 7/15/16 that were not in Resident #1's record at the facility revealed:</p> <ul style="list-style-type: none"> <li>-There was an order dated 2/10/16 for Miralax 17grams, take one capful mixed with 16 ounces of water daily.</li> <li>-There was an order dated 4/15/16 for Protonix 40mg twice daily before breakfast and supper.</li> <li>-There was an order dated 4/20/16 to discontinue Seroquel.</li> <li>-There was an order dated 4/28/16 for Clindamycin 300mg four times daily for seven days.</li> <li>-There was an order dated 6/1/16 for Risperdal 2mg, take one tab twice daily.</li> <li>-There was an order dated 6/29/16 for Hydroxyzine 15mg three times daily.</li> </ul> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>Refer to interview with the Administrator on 07/18/16 at 9:05am.</p>	C 249		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 249	<p>Continued From page 69</p> <p>2. Review of Resident #2's current FL2 dated 5/2/16 revealed diagnoses included schizoaffective disorder, intellectual disability-moderate, dyspepsia, diabetes mellitus type 2.</p> <p>Review of a physician's order dated 6/29/16 provided by the Supervisor-in-Charge (SIC) on 7/14/16 at 9:50am revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for Saphris 5mg, one tablet at bedtime.</li> <li>-There was an order to discontinue Geodon and Tegretol.</li> <li>-There was an order for Luvox 100mg, 1 ½ tablet at bedtime.</li> <li>-There was an order to change Vistaril 50mg to one tablet at bedtime.</li> <li>-There was an order to decrease Cogentin to 1mg, one tablet at bedtime.</li> <li>-There was an order for Depakote DR 250mg, one tablet in the morning and two tablets at bedtime.</li> </ul> <p>Review of physician orders provided by the pharmacy on 7/15/16 that were not in Resident #2's record at the facility revealed:</p> <ul style="list-style-type: none"> <li>-There was an order dated 4/29/16 for Atarax 10mg, take one tablet every six hours as needed for anxiety.</li> <li>-There was an order dated 4/29/16 for Geodon 40mg, take one capsule daily before dinner and 20mg, take one capsule daily with breakfast.</li> <li>-There was an order dated 5/13/16 for Flagyl 500mg twice daily for 7 days.</li> <li>-There was an order dated 5/13/16 for Diflucan 150mg every other day times 3 doses.</li> </ul> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>Refer to interview with the Administrator on</p>	C 249		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 249	<p>Continued From page 70</p> <p>07/18/16 at 9:05am.</p> <p>3. Review of Resident #4's current FL-2 dated 07/18/16 revealed diagnoses included schizophrenia, depression, diabetes, hyperlipidemia, and gastroesophageal reflux disease (GERD).</p> <p>A. Review of Resident #4's record on 07/14/16 revealed the most current FL-2 in his record was dated 11/19/15; there were no other FL-2s in the record.</p> <p>Further review on Resident #4's record on 07/28/16 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 had two additional FL-2's in his record that were not in the record on 07/14/16.</li> <li>-The first FL-2 was dated 01/04/16.</li> <li>-The second FL-2 found on 07/28/16 was a new FL-2 dated 07/18/16 obtained since the record review was completed on the start date of the survey (07/14/16).</li> </ul> <p>Review of the Drug Regimen Review dated 06/24/16 revealed:</p> <ul style="list-style-type: none"> <li>-There was documentation that Resident #4's FL-2 was dated 11/19/15.</li> <li>-There was no mention of Resident #4's FL-2 dated 01/04/16.</li> </ul> <p>B. Review of physician orders provided by the pharmacy on 7/15/16 that were not in Resident #4's record at the facility revealed:</p> <ul style="list-style-type: none"> <li>-There was an order dated 05/17/16 for Risperdal 4mg, take two daily.</li> <li>-There was an order dated 05/17/16 for citalopram 20mg. daily at 08:00am.</li> <li>-There was an order dated 05/17/16 for Benztropine 1mg. take one twice daily.</li> <li>-There was an order dated 05/17/15 for Depakote</li> </ul>	C 249		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 249	<p>Continued From page 71</p> <p>ER 500mg, take one three times daily, -There were orders dated 05/17/16 to discontinue Risperdol 3mg and Trazadone.</p> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>Refer to interview with the Administrator on 07/18/16 at 9:05am.</p> <p>_____ Interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm revealed: -The SIC kept the paper work, orders, and progress notes from medical appointments in her car in a notebook. -She kept the information in her notebook until she could get back from the appointments and go to another facility to fax the orders to the pharmacy.</p> <p>Interview with the Administrator on 07/18/16 at 9:05am revealed: -The Administrator did not know why the documentation was not kept in the records. -The SIC told her all orders were in the records.</p>	C 249		
C 261	<p>10A NCAC 13G .0904 (b-2) Nutrition And Food Service</p> <p>10A NCAC 13G .0904 Nutrition And Food Service</p> <p>Food Preparation and Service in Family Care Homes:</p> <p>(2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an</p>	C 261		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 261	<p>Continued From page 72</p> <p>individual basis and shall be based on documented needs or preferences of the resident.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents were provided with a napkin at meal service for 4 of 4 residents (#1, #2, #3, #4).</p> <p>The findings are:</p> <p>Observation of the breakfast meal on 07/14/16 at 06:55am revealed: -Residents were served a breakfast meal consisting of one variety of cereal and milk. -Four of four residents did not have a napkin at the meal service.</p> <p>Confidential interview with three residents revealed: -Residents were not given napkins or paper towels at meals and there were not any napkins on the table at meals. -When residents asked for napkins, "they don't have any." -One resident used a bath towel when the resident needed a napkin. -Residents ask staff for napkins and staff told them they are out of napkins. -One resident needed a napkin "sometimes" but there were never any napkins available.</p> <p>Confidential staff interview revealed: -"They won't keep napkins or paper towels for residents to use at meals." -"It's not right."</p>	C 261		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 261	<p>Continued From page 73</p> <p>Confidential interview with a second staff member revealed:</p> <ul style="list-style-type: none"> <li>-When asked about the use of napkins the staff responded "we don't really use them."</li> <li>-Napkins were being "wasted" so staff did not put napkins on the table at meals.</li> <li>-If residents asked for a napkin, staff gave them a paper towel.</li> <li>-The staff had not received any complaints from residents about not having a napkin at meals.</li> <li>-The Administrator was aware napkins were not being placed on the table at meals.</li> </ul> <p>Interview with the Administrator on 07/18/16 at 09:05am revealed:</p> <ul style="list-style-type: none"> <li>-Napkins were last purchased on 06/24/16.</li> <li>-The Administrator had not received any complaints from residents about the lack of napkins at meals.</li> <li>-The Administrator thought "people steal supplies."</li> </ul>	C 261		
C 280	<p>10A NCAC 13G .0904(d)(3)(H) Nutrition and Food Service</p> <p>10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure water was served at meals for 5 of 5 residents.</p> <p>The findings are:</p>	C 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 280	<p>Continued From page 74</p> <p>Observation of the breakfast meal on 07/14/16 at 06:55am revealed: -Residents were served a breakfast meal consisting of one variety of cereal and milk. -Four of four residents had tea as a beverage. -Four of four residents were not served water with the breakfast meal.</p> <p>Observation of the breakfast meal on 07/28/16 at 06:48am revealed: -Residents were served a breakfast meal consisting of pancakes and syrup, scrambled eggs, and bacon. -Four of four residents had tea as a beverage; one resident had cranberry juice as a beverage. -Five of five residents were not served water with the breakfast meal.</p> <p>Confidential interview with two residents revealed: -Water was not served at any of the meals. -Only tea was served at the meals. -Water or milk was not served at meals; "you can get tea though."</p> <p>Confidential interviews with 3 staff members revealed: -The staff member on duty was responsible for preparing and serving the meals. -Staff were aware water was supposed to be served with the meal service. -Two of three staff reported water was not served at meals. -The residents did not drink the water therefore water was not served. -The residents liked to drink tea at meals.</p>	C 280		
C 288	10A NCAC 13G .0905(a) Activities Program	C 288		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 288	<p>Continued From page 75</p> <p>10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and review of the facility's Activity Calendar, the facility failed to provide an activity program that promoted active involvement by the residents.</p> <p>The findings are:</p> <p>Observation during the initial facility tour on 07/14/16 at 7:45am revealed there was an activity calendar hanging on the wall in the dining room dated July 2016.</p> <p>Confidential interview with a resident revealed: -The resident did not know what the activity calendar was. -The facility did not have any daily activities. -The facility did not have any games or coloring books</p> <p>Confidential interview with a second resident revealed residents never did any of the activities posted on the activity calendar.</p> <p>Confidential interview with a third resident revealed: -The facility did not have a van to go to activities. -"We can't all fit in their car, so one of us has to stay home."</p> <p>Review of the July 2016 Activity Calendar revealed: -There were activities scheduled daily such as church, games including Trouble, Scrabble and</p>	C 288		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 288	<p>Continued From page 76</p> <p>UNO, puzzles, coloring, bible study, and movie night. -On 07/28/16 from 5:00pm-7:00pm "coloring book night " was scheduled from 5:00-7:00pm.</p> <p>Observation on 07/28/16 from 5:00pm-6:00pm revealed there was no activity taking place in the facility.</p> <p>Confidential interview with a staff member revealed: -The facility did not have any games; the facility had puzzles but "never" used them. -None of the activities posted on the Activity Calendars took place.</p> <p>Interview with the Administrator on 07/14/16 at 1:48pm revealed the facility had an activity program and residents went to outings such as the "store" or "library."</p>	C 288		
C 296	<p>10A NCAC 13G .0906 (a) Other Resident Services</p> <p>10A NCAC 13G .0906 Other Resident Services</p> <p>(a) Transportation. The administrator must assure the provision of transportation for the residents to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident is not to be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.</p>	C 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 296	<p>Continued From page 77</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to assure the provision of transportation for the residents to and from the hospital, emergency room, and medical appointments for 4 of 4 residents who resided in the facility. The findings are:</p> <p>1. Confidential staff interview revealed: -The biggest issue with transportation was when one resident needed to go somewhere, and the others were not able to fit in one car. -The Supervisor-In-Charge (SIC) and the Administrator were called from the hospital if someone needed to be picked up. -The residents had missed appointments if the SIC had one resident at an appointment, and another resident had an appointment somewhere else. -The SIC was responsible for taking the residents from three facilities to their medical appointments. -"Last week" the SIC told Resident #1 he had an appointment and she would pick him up from PSR, but "I think something happened" and the SIC had to deal with it and could not take Resident #1 to the appointment.</p> <p>Interview with the Administrator on 07/14/16 at 12:45pm revealed: -There was a "mix up" about Resident #1's urology appointment on 07/14/16 because the SIC "did not have a car this morning."</p> <p>2. Interview with Resident #4 on 7/21/16 at 9:42am revealed: -If the residents went to the hospital, the staff</p>	C 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 296	<p>Continued From page 78</p> <p>would not come get the residents. -The staff would tell the residents that "they were too busy and to wait until tomorrow."</p> <p>Review of a hospital Emergency (ED) Department Notes for Resident #4 dated 01/21/16 revealed: -Resident #4 was evaluated in the ED on 01/21/16 for drainage around his colostomy wound and complaints of abdominal pain and discharged 01/21/16. -"Patient does not have a ride home; patient to sleep in main waiting room until morning. Given blankets for comfort. Patient agreeable and cooperative."</p> <p>Interview with the Supervisor-In-Charge (SIC) on 07/28/16 at 3:40pm revealed: -Staff were supposed to get residents when they were discharged from the hospital. -There had been times when police brought residents back to the facility after they were discharged from the hospital. -If the SIC was working and could not leave, the SIC let the hospital know the situation and "sometimes" police brought the resident home. -If it was the middle of the night and the SIC could not fit all of the residents in her car, she let the hospital know the situation and sometimes the police brought the resident home. -If the SIC had her van, all residents could fit in the van, but all residents could not fit in her car.</p> <p>Review of the Plan of Protection submitted by the facility dated 07/28/16 revealed: -The Administrator would assure residents' transportation needs were accommodated. -The Administrator would make sure there were enough vehicles on the premises for transporting</p>	C 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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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 296	Continued From page 79  residents; there would be two cars or one van to transport residents as needed.  THE CORRECTION DATE OF THIS TYPE B VIOLATION SHALL NOT EXCEED 09/11/16.	C 296		
C 301	10A NCAC 13G .0906 (f)(1)-(4) Other Resident Services  10A NCAC 13G .0906 Other Resident Services  (f) Visiting. (1) Visiting in the home and community at reasonable hours shall be encouraged and arranged through the mutual prior understanding of the residents and administrator; (2) There must be at least 10 hours each day for visitation in the home by persons from the community. If a home has established visiting hours or any restrictions on visitation, information about the hours and any restrictions must be included in the house rules given to each resident at the time of admission and posted conspicuously in the home; (3) A signout register must be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and telephone number of the responsible party; (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home must immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.	C 301		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 301	<p>Continued From page 80</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to maintain a signout register for planned visits and scheduled absences which indicated the resident's departure time, expected time of return, and the name and telephone number of the responsible party for 2 of 6 sampled residents (#5, #6). The findings are:</p> <p>1. Review of Resident #5's FL-2 dated 05/16/16 revealed: -Diagnoses included bipolar disorder, Tourette's syndrome, and autism spectrum disorder. -The recommended level of care was documented as family care home. -The admission date to the current location was not documented.</p> <p>Review of Resident #5's Assessment and Care Plan dated 05/16/16 revealed: -Resident #5 had a history of developmental disabilities and mental illness. -Resident #5 had a history of wandering and being verbally abusive.</p> <p>Interview with the Administrator revealed on 07/18/16 at 9:05am revealed Resident #5 was first admitted to the facility on 11/29/14 and was re-admitted to the facility on 07/25/15.</p> <p>Review of the Resident Register dated 11/29/14 revealed Resident #5's family member was his legal guardian.</p> <p>Review of the staff communication notes for Resident #5 revealed: -On 01/08/16, Resident #5 walked to the store. -On 02/23/16, Resident #5 "signed out for a</p>	C 301		

Division of Health Service Regulation

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C 301	<p>Continued From page 81</p> <p>walk."</p> <p>Review of the facility's signout register from January 2015-March 2015 revealed:</p> <ul style="list-style-type: none"> <li>-There were multiple occasions that Resident #5 signed out of the facility.</li> <li>-There was no responsible party's contact information on the sign out sheets.</li> <li>-There were several dates that Resident #5 signed out, but the column for signing in was left blank.</li> <li>-There were no sign out sheets after March 2015 for Resident #5.</li> </ul> <p>Telephone interview with Resident #5's family member/guardian on 7/26/16 at 1:02pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff treated Resident #5 well, especially the first year, "but did not monitor him like they should have."</li> <li>-Resident #5 was paranoid, heard voices, had "meltdowns," "emotional issues," and was "borderline retarded."</li> <li>-Resident #5 required supervision "at all times."</li> <li>-Resident #5 was "out many times without supervision."</li> <li>-The staff at the facility slept at night; "residents come and go as they please all night."</li> <li>-In 2016 before he was "expelled" from the facility, Resident #5 "walked off" to a pool hall and was smoking pot</li> </ul> <p>Interview with the SIC on 07/28/16 at 3:40pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff could not stop residents from signing out of the facility unless they had a guardian or "we get them a guardian."</li> <li>-Resident #5 had a guardian.</li> </ul> <p>Resident #5 was not available for interview.</p>	C 301		

Division of Health Service Regulation

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C 301	<p>Continued From page 82</p> <p>Resident #5's physician was not available for interview.</p> <p>Refer to Visitation Policy.</p> <p>Refer to the facility House Rules.</p> <p>2. Review of Resident #6's FL2 dated 9/22/15 revealed diagnoses included schizoaffective disorder, cocaine use disorder-severe, and cannabis use disorder-severe.</p> <p>Review of Resident #6's Resident Register revealed: -Resident #6 was admitted to the facility on 2/17/14. -She was discharged on 11/10/15. -The resident's family member was her responsible party.</p> <p>Review of the assessment and care plan for Resident #6 dated 5/12/15 revealed: -Resident #6 was independent with all activities of daily living. -She was physically abusive and injurious to self and others. -She had a history of substance abuse and mental illness.</p> <p>Review of the staff communication notes for Resident #6 revealed: -From 6/28/15- 10/31/15, Resident #6's was documented as signing out of the facility 34 times. -On 8/16/15, "[Resident #6's name] signed out for the rest of the week" was documented. -On 8/29/15, the documentation revealed that Resident #6 had signed out and came back with a black eye. Resident #6 called 911 because "she</p>	C 301		

Division of Health Service Regulation

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C 301	<p>Continued From page 83</p> <p>thought her rib was cracked." After being released from the hospital, "she decided to stay in a hotel that night." -On 8/30/15, the documentation revealed that Resident #6 returned to the facility and signed back out. -On 9/14/15, Resident #6 signed out most of the evening was documented. -On 10/18/15, Resident #6 went out late and came back "drunk .....falling over the place and upset the clients."</p> <p>Review of the facility's signout register from January 2015-March 2015 revealed: -There were multiple occasions that Resident #6 signed out of the facility. -There was no responsible party's contact information on the sign out sheets. -There were several dates that Resident #6 signed out, but the column for signing in was left blank. -There were no sign out sheets after March 2015.</p> <p>Review of the county Sheriff's office incident/investigation report dated 9/15/15 revealed: -Resident #6 contacted 911 at 8:20pm because "she took a bottle of medicine" and was taken to the emergency room (ER). -Resident #6 reported that four days prior, she had been raped. -At 2:00am, Resident #6 reported that she asked the male to take her home. On the way, the male pulled the car down a cornfield and stopped. Resident #6 tried running from the vehicle, but the male grabbed her by the feet and threw her down on in the cornfield. Resident #6 tried to get away, but the male held her down and started choking her. -Resident #6 reported that she stopped fighting</p>	C 301		

Division of Health Service Regulation

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C 301	<p>Continued From page 84</p> <p>and "let him finish." Resident #6 was dropped off at a friend's house at 3:00am.</p> <p>-Since the incident, Resident #6 reported to the officer that she had consumed a large amount of alcohol and pills, and engaged heavily in smoking crack in an attempt to kill herself.</p> <p>Interview attempted on 7/28/16 at 8:50am with Resident #6's mental health provider, but the psychiatrist was out of town until 8/3/16 and the psychiatrist on duty was not familiar with Resident #6.</p> <p>Telephone interview with Resident #6's family member on 7/28/16 at 2:08pm revealed:</p> <p>-The family member had never visited the facility.</p> <p>-Resident #6's care had been released to another family member.</p> <p>-The family member knew that Resident #6 would go stay off with friends.</p> <p>-Resident #6 had a problem with suicide attempts and had been hospitalized once for taking a bunch of medication.</p> <p>Telephone interview with a second family member for Resident #6 at 7/28/16 at 5:30pm revealed:</p> <p>-The family member had visited the facility a few times.</p> <p>-Resident #6 would be at places she should not have been.</p> <p>-There were times when there was no staff at the facility with the residents.</p> <p>-Resident #6 would leave and go stay with people she did not know.</p> <p>-The staff at the facility could never tell the family member where Resident #6 was or who she was with.</p> <p>Telephone interview with Resident #6 revealed she would sign out and let the staff know she</p>	C 301		

Division of Health Service Regulation

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C 301	<p>Continued From page 85</p> <p>would be with friends.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 7/28/16 at 4:10pm revealed: -Resident #6 was her own guardian and would sign herself out. -Resident #6 did not follow facility policy which was why she left the facility. -There were times when Resident #6 would be gone for two days, but staff always knew where she was because Resident #6 would call.</p> <p>Telephone interview with the RN at Resident #6's PAC office revealed: -Resident #6 required the supervision of the family care home or she could not have been admitted to the facility. -Resident #6 should not have been signing out alone for days at a time from the facility.</p> <p>Telephone interview with Resident #6's PAC on 07/18/16 at 1:55pm revealed: -The PA evaluated Resident #6 on 10/28/16 and was concerned because she reported she had been raped 4 weeks prior to the PAC visit and did not go the hospital until 4 days after the rape occurred. -The PAC was not notified of Resident #5 being raped prior to 10/28/16. -The PAC "never saw her again." -From what the PAC understood, the facility allowed residents to "come and go as they please." -The residents of the home required supervision; the PAC had never written any orders or checked the box on the form to allow the residents to leave the facility without supervision.</p> <p>Refer to Visitation Policy.</p>	C 301		

Division of Health Service Regulation

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C 301	Continued From page 86 Refer to the facility House Rules.  Review of the facility's policy entitled "Visitation in the Facility" revealed "a sign out register shall be maintained for planned visiting and other scheduled absences which indicates the resident's departure times, expected time of return, and the name and telephone number of the responsible party. Each resident is expected to sign in and out."  Review of the "House Rules" revealed there was a rule which read "sign in and out when leaving the facility."	C 301		
C 311	10A NCAC 13G .0909 Residents' Rights  10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.  This Rule is not met as evidenced by: TYPE B VIOLATION  Based on observations and interviews the facility failed to assure 4 of 4 residents sampled (#1, #2, #3, #4) were treated with respect, consideration and dignity as evidenced by not allowing residents to have a second helping at meals, not allowing residents the choice of attending a psychosocial rehabilitation (PSR) program, staff talking to residents in a disrespectful manner, locking one resident (#3) out of the facility, and not allowing one resident (#4) to attend outings.	C 311		

Division of Health Service Regulation

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C 311	<p>Continued From page 87</p> <p>The findings are:</p> <p>1. Review of Resident #4's current FL-2 dated 07/18/16 revealed diagnoses included schizophrenia, depression, diabetes, hyperlipidemia, and gastroesophageal reflux disease (GERD). Interview with Resident #4 on 07/14/16 at 7:01am revealed: -Resident #4 had a colostomy for "4 or 6 months" and "recently" had surgery to reverse the colostomy. -When Resident #4 had a colostomy, staff would not let him go on outings with staff and other residents because staff told him "you stink"; Resident #3 had to stay at the facility alone. -A month and half ago, on a weekend, a staff member asked Resident #4 to stay alone in the facility while all the other residents went on an outing with a staff member because everyone would not fit in the staff member's car; Resident #4 was alone in the facility for" 2-3 hours".</p> <p>Confidential staff interview revealed: -Resident #4 used to have a colostomy; "it stunk so bad." -Resident #4 did not go on some of the outings, because there was not enough room in her car; it was not because the colostomy smelled bad.</p> <p>Confidential interview with a second staff revealed Resident #4 was sometimes left at the facility or he would walk to a pool hall nearby and would not be at the facility when everyone else left the facility.</p> <p>Telephone interview with Resident #6's Physician Assistant (PAC) on 07/18/16 at 1:55pm revealed:</p>	C 311		

Division of Health Service Regulation

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C 311	<p>Continued From page 88</p> <ul style="list-style-type: none"> <li>-From what the PAC understood, the facility allowed residents to "come and go as they please."</li> <li>-Based on Resident #3's diagnoses and medications, Resident #3 should not be left alone in the facility and the PAC would not expect to see Resident #3 signed out to walk to the store or others places alone.</li> <li>-The residents of the home required supervision; the PAC had never written any orders or checked the box on the form to allow the residents to leave the facility without supervision.</li> </ul> <p>Telephone interview with Resident #4's psychiatrist contracted through the PSR program on 07/18/16 at 12:50pm revealed:</p> <ul style="list-style-type: none"> <li>-Resident #4 "has severe and persistent mental illness."</li> <li>-When asked if Resident #4 was stable to be left alone at the facility, the psychiatrist wanted to know "why would staff leave him alone?"</li> </ul> <p>2. Confidential interviews with four residents on 07/21/16 revealed:</p> <ul style="list-style-type: none"> <li>-The Administrator would tell the residents, "You smell musky. You should wash every day."</li> <li>-The Administrator called the residents "disgusting."</li> <li>-The residents couldn't help they were not able to shower because of the water problems at the facility. "They don't give dog about us."</li> <li>-Staff told the resident that the resident stunk and smelled bad; it really took a toll on the resident.</li> <li>-Staff would yell at the residents to take a shower.</li> <li>-Sometimes staff were nice to the residents, sometimes staff were not nice to the residents.</li> <li>-The SIC yelled at the resident "for saying stuff" to other people; the resident did not want to get in trouble for "saying stuff."</li> <li>-The SIC cursed at one resident and the resident</li> </ul>	C 311		

Division of Health Service Regulation

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C 311	<p>Continued From page 89</p> <p>"cursed her right back."</p> <p>Telephone Interview with a resident's family member on 07/27/16 at 3:16pm revealed: -The resident told the family member that staff made fun of the resident. -The resident had been picked on.</p> <p>Interview with the SIC on 07/28/16 at 4:40pm revealed: -The SIC encouraged residents to come to her with problems -The SIC expected staff to treat residents like they would want to be treated.</p> <p>Interview with the Administrator on 07/28/16 at 4:30pm revealed: -The Administrator expected staff to treat residents with respect and residents to treat staff with respect. -The Administrator had not had any complaints related to residents' rights recently; the last complaint came from a resident who no longer lived in the facility.</p> <p>3. Review of Resident #3's current FL-2 dated 06/08/16 revealed: -Diagnoses included schizophrenia, depression, hypertension, and type 2 diabetes. -Resident #3 was intermittently disoriented. -The admission date to the facility was documented as 04/13/16.</p> <p>Review of Resident #3 's Assessment and Care Plan revealed: -There was no assessment documented on the Care Plan. -Resident #3 had a history of wandering and mental illness. -Resident #3 was forgetful-"needs reminders."</p>	C 311		

Division of Health Service Regulation

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C 311	<p>Continued From page 90</p> <p>-The Care Plan was signed by the Physician Assistant (PAC) and dated 06/08/16.</p> <p>Review of entries documented in the staff communication notebook revealed:</p> <p>-On 07/16/16 Resident #3 got up around 4:00am to smoke; "I locked him out for a couple of mins. (minutes) and then I let him back in."</p> <p>-On 07/17/16, Resident #3 "got up in the middle of the night around 2:00am and went outside to smoke a cigar. Lock him out again but that don't matter to him."</p> <p>Confidential interview with two residents revealed both residents reported staff locked residents out if they got out after 10:00pm.</p> <p>Interview with Resident #3 on 07/21/16 at 10:50am revealed:</p> <p>-It was a rule that residents could not go outside after 10:00pm or staff would lock them out.</p> <p>-Resident #3 went outside after 10:00pm to smoke; "they lock me out."</p> <p>-The last time Resident #3 had been locked out was 2 or 3 days ago for 15-20 minutes.</p> <p>Observation on 07/28/16 at 06:29am revealed Resident #3 was walking on the side of Highway 421 near the store/gas station.</p> <p>Interview with the clerk at the store on 7/28/16 at 9:45am:</p> <p>-The clerk described an individual of Resident #3's description coming in to the store to purchase cigarettes, food, and drinks; the clerk had not had any problems with Resident #3.</p> <p>-Somebody at the facility called and told clerk not to sale the residents certain stuff and he told her that it was not his job to monitor what they buy.</p>	C 311		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 311	<p>Continued From page 91</p> <p>Observation on 07/28/16 at 06:25am revealed there was a sign hanging on the wall to the left of the door in the living room which read "no smoking after 10:00pm; door will be locked. Thank you ..."</p> <p>Confidential staff interviews revealed:</p> <ul style="list-style-type: none"> <li>-Residents who went outside after 10:00pm were "locked out."</li> <li>-The SIC told the staff to lock the residents out.</li> <li>-The residents knew the policy of doors closing at 10:00pm; "I made it very clear to them."</li> <li>-Resident #3 liked to go outside at "all times of the night" to smoke.</li> <li>-Resident #3 had been locked outside "to try to teach him something"; the staff "felt bad" about locking him out.</li> <li>-The residents went to a Psychosocial Rehabilitation (PSR) Program every day; the staff left the facility after the residents were picked up by the van for PSR.</li> <li>-If a resident did not go to PSR, the staff on duty had to wait until another staff member came to pick up the resident.</li> <li>-There had not been any incidents when a resident had been locked out of the facility after not going to the PSR program for a day.</li> </ul> <p>Telephone interview with the Supervisor-in-Charge (SIC) on 7/18/16 at 4:35pm revealed:</p> <ul style="list-style-type: none"> <li>-The residents would go outside after hours at 11:00pm, 12:00am, and 1:00am for example.</li> <li>-Staff would tell the residents not to go out and the residents would anyway, so staff locked them out.</li> <li>-The SIC had never locked any of the residents out of the facility, but she knew other staff did.</li> </ul> <p>Telephone interview with Resident #3's PAC on</p>	C 311		

Division of Health Service Regulation

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C 311	<p>Continued From page 92</p> <p>07/18/16 at 1:55pm revealed: -From what the PAC understood, the facility allowed residents to "come and go as they please." -The PAC had no knowledge of staff locking Resident #3 out of the home. -When asked if Resident #3 was stable enough to be left alone or to sign out alone and walk to the store or other places, the PAC laughed "in disbelief." -Resident #3 had a diagnosis of schizophrenia "you would not want to lock him outside of the residence at night."</p> <p>4. Confidential interview with two residents revealed: -The residents did not have the choice of attending a day program. -The residents were made to go to the day program because they don't have any staff at the facility during the day to watch the residents. -The day before yesterday, (07/19/16), the SIC told the resident "my [expletive] better be on the bus to go to PSR tomorrow." -The two residents did not want to go to the day program.</p> <p>Confidential staff interview revealed every resident that had Medicaid "has to go to PSR."</p> <p>Interview with the Program Director and Executive Director on 07/18/16 at 12:15pm revealed: -The facility Administrator expected all the residents to receive services at the PSR program. -Not all residents qualified for the PSR program. -The Program Director had spoken with the Administrator and explained that all residents did not qualify for PSR and all residents were not suitable for PSR due to their current health</p>	C 311		

Division of Health Service Regulation

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C 311	<p>Continued From page 93</p> <p>status.</p> <p>5. Confidential interview with four residents revealed:                      -The facility ran out of food sometimes.                      -On 07/20/16, the SIC said she was waiting on the Administrator for food.                      -The facility ran out of meat and cereal.                      -There was not enough to eat at the facility; the resident asked for second helping but the request was not honored" sometimes."                      -" I've been hungry."                      -We are not allowed to get seconds.                      -Since the survey started and over the last few days they've been giving seconds so "y'all won't get them in trouble."                      -The Administrator said we get enough food.</p> <p>Review of an entry in the staff communication notebook dated 05/23/16 revealed:                      -"Staff please keep refrigerator lock [sic] up at all times [sic] unless you in the kitchen other wise [sic] lock it up. If I come down here and it unlock [sic] you will be written up."                      -"The client is [sic] drinking up everything. [Administrator's name] can't keep buying..."                      -The entry was signed by the Supervisor in Charge.</p> <p>Observation on 07/14/16 at 08:48am revealed:                      -The facility had at least a 3 day supply of perishable food on hand.                      -The facility had at least a 5 day supply of non-perishable food on hand.</p> <p>Confidential staff interviews revealed:                      -There was not enough food at times.                      -Staff tried to go by the menus but sometimes what was on the menus was not available; but there was always something they could serve.</p>	C 311		

Division of Health Service Regulation

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C 311	<p>Continued From page 94</p> <ul style="list-style-type: none"> <li>-There was usually enough food cooked at meals for residents who wanted a second portion.</li> <li>-The facility ran out of condiments such as mayonnaise and ketchup.</li> <li>-The facility ran out of peanut butter, and jelly "a lot."</li> <li>-The facility ran out of sandwich bread, milk, and cereal; the facility "never" had butter or margarine.</li> <li>-The facility ran "low" on sugar and rice sometimes.</li> <li>-Staff had noticed there was more food in the cabinets since the survey started.</li> <li>-Only Resident #2 asked for second portions at meals.</li> </ul> <p>Confidential interview with a resident's family member revealed the facility ran out of food and no fruit was ever served at all.</p> <p>Telephone interview with the SIC on 07/18/16 at 4:35pm revealed the Administrator shopped for groceries every two weeks.</p> <p>Interview with the SIC on 07/28/16 at 3:40pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff always cooked enough food for residents to get second portions.</li> <li>-If the facility ran out of anything, they were supposed to call or text the Administrator and she would bring it.</li> </ul> <p>Interview with the Administrator on 07/18/16 at 9:05am revealed:</p> <ul style="list-style-type: none"> <li>-Staff texted her when the food supply was low.</li> <li>-The Administrator was responsible for purchasing food for the facility.</li> <li>-The Administrator went to the grocery store to purchase food for the home every two weeks.</li> </ul>	C 311		

Division of Health Service Regulation

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C 311	Continued From page 95  <u>Review of the Plan of Protection dated 07/28/16 revealed:</u> -The Administrator will meet with staff regarding residents' rights. -Staff would treat all residents with dignity and respect. -The Administrator would schedule residents' rights training.	C 311		
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 A1 VIOLATION Based on record reviews and interviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 residents sampled (#1, #2, #3) including errors with oral antidiabetic medications (#1, #2), antibiotics (#1, #2), antipsychotics (#1, #2), an antiulcer (#2), a pain medication (#1), an anti-anxiety medication (#1), a probiotic, and gastroesophageal reflux medication (#3) resulting in residents going without medications for several days. The findings are:	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 96</p> <p>1. Review of Resident #1's current FL2 dated 11/23/15 revealed: -Diagnoses included major depressive disorder, hypertension, diabetes, chronic obstructive pulmonary disease, and hepatitis C. -Medication orders included Metformin (an antidiabetic) 1000mg, one tablet twice daily, Seroquel (an antipsychotic used to treat depression) 100mg at bedtime and 50mg twice daily, Lyrica (a pain medication used to treat nerve and muscle pain) 100mg, one tablet every 8 hours. -There was no order to obtain finger stick blood sugars.</p> <p>A. Review of a Patient Chart Report from the Primary Care Provider's (PCP) office dated 04/26/16 revealed: -Resident #1 was seen for a right axillary wound that was drained at the ED on 04/17/16. -The packing that was placed in the ED had not been removed. -A wound culture was obtained that was positive for staphylococcus aureus (a gram positive bacteria frequently found on the skin). -Resident #1 was prescribed Clindamycin (an antibiotic) and was to follow-up in two days.</p> <p>Review of a second Patient Chart Report from the PCP's office dated 04/28/16 revealed: -Resident #1 saw the Pysician Assistant (PA) for a recheck of the right axilla wound. -The resident had not started the antibiotic as of 04/28/16, because "group home had not gotten the antibiotic." -The PA documented that the caregiver did not fax the prescription to the pharmacy for the antibiotic, so the antibiotic had not been started yet. The PA made the caregiver with Resident #1</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 97</p> <p>aware that the antibiotic was "to start TODAY with no exceptions."</p> <p>Review of Resident #1's Medication Administration Record (MAR) for April 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There was a handwritten entry for Clindamycin 300mg four times daily for seven days scheduled to be administered at 8:00am, 12:00pm, 4:00pm, and 8:00pm.</li> <li>-Resident #1 received his first dose of Clindamycin on 04/29/16 at 12:00pm.</li> </ul> <p>Telephone interview with the PA on 07/18/16 at 1:55pm revealed:</p> <ul style="list-style-type: none"> <li>-The PA evaluated Resident #1 in the office on 04/26/16 for an abscess wound under his arm; the "wound" had pus coming out of it and was red.</li> <li>-The abscess had been drained and packed in the ED on 04/19/16, 7 days prior to this visit on 04/26/16.</li> <li>-On 04/26/16, the abscess still had the original packing in it from the ED visit.</li> <li>-Resident #1 told the PA he had asked the facility to bring him in sooner for follow up.</li> <li>-The PA had to re-open the abscess and he prescribed antibiotics for Resident #1 on 04/26/16.</li> <li>-Resident #1 was scheduled for another follow up on 04/28/16.</li> <li>-When Resident #1 came to the follow up appointment on 04/28/16, he had not been started on the antibiotics prescribed by the PA on 04/26/16.</li> <li>-The PA told the "caregiver" (facility staff) that Resident #1 was to start the antibiotics that day (04/28/16), "no exceptions."</li> <li>-Resident #1 was scheduled for a follow up appointment on 05/03/16; Resident #1 did not</li> </ul>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 98</p> <p>come to the appointment on 05/03/16. -The PA evaluated Resident #1 again on 05/11/16 and the wound was healing.</p> <p>Interview with Resident #1 on 07/21/16 at 9:17 am revealed: -The staff did not give him the antibiotic the PA ordered. -"I don't know why they would do that to me."</p> <p>Telephone interview with the PA on 07/18/16 at 1:55pm revealed the PA expected Resident #1 to recieve all medications as ordered.</p> <p>B. Review of physician orders for Resident #1 revealed: -There was an emergency room (ER) order dated 01/24/16 for Metformin 1000mg, take one tablet two times daily. -There was a second ER discharge order dated 04/17/16 for Metformin 1000mg, take one tablet two times daily. -There was a third ER discharge order dated 06/16/16 for Metformin 1000mg, take one tablet two times daily. -There was a fourth ER discharge order dated 06/29/16 for Metformin 1000mg, take one tablet two times daily.</p> <p>Review of current medications on the "Patient Chart Report" at the primary care provider's (PCP) office revealed: -Current medications on 02/9/16 listed Metformin 1000mg, one tablet twice daily. -Metformin 1000mg, one tablet twice daily was listed as a current medication on 04/26/16 and 04/28/16. -On 05/11/16, Metformin 1000mg, one tablet twice daily was listed.</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 99</p> <p>Review of Resident #1's MAR for April, May, June, and July 2016 revealed: -There was a computer generated entry for Metformin 500mg, take one tablet twice daily with meals. -The scheduled administration times were 8:00am and 5:00pm.</p> <p>Review of copies of orders provided by the pharmacy on 07/15/16 from January 1, 2016-June 30, 2016 revealed there was no order for Metformin 500mg, take one tablet twice daily with meals.</p> <p>Review of pharmacy dispensing records revealed: -Metformin 500mg tablets had been dispensed since January 1, 2016. -There was no record of 1000mg tablets of Metformin being dispensed.</p> <p>Observation of medications on hand on 07/14/16 at 10:50am revealed there were 6 tablets of Metformin 500mg on the medication cart that had been dispensed on 06/20/16.</p> <p>Telephone interview with the pharmacy provider on 07/27/16 at 8:24am revealed: -The pharmacy had never dispensed 1000mg tablets. -There was a drug review on 06/20/16 and a FL2 dated 06/30/16 that listed Metformin 500mg, one tablet twice daily. -The pharmacy could not find another order for Metformin 500mg.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 100</p> <p>07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Physician's Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>C. Review of physician orders for Resident #1 revealed:</p> <ul style="list-style-type: none"> <li>- On 01/14/16 there was a new order from the mental health provider for Seroquel 100mg three times daily at 8:00am, 4:00pm, and 8:00pm.</li> <li>-On 02/9/16, current medications listed on the Patient Chart Report at the PCP office revealed Seroquel 50mg twice daily and 100mg at bedtime.</li> <li>- On 02/25/16 there was a new order from the mental health provider for Seroquel 200mg three times daily at 8:00am, 4:00pm, and 8:00pm.</li> <li>-On 04/20/16, there was an order from the mental health provider to discontinue Seroquel.</li> <li>-On 04/26/16, 04/28/16, and 05/11/16, current medications listed on the Patient Chart Report at the PCP office revealed Seroquel 50mg twice daily and 100mg at bedtime.</li> <li>-Current medications listed on the emergency room (ER) discharge orders dated 06/14/16 revealed Seroquel was not listed.</li> <li>-On 06/29/16, there was a new order from the mental health provider for Seroquel 200mg twice daily for one week, then 100mg twice daily for one week, then 100mg at bedtime for one week, and then discontinue.</li> </ul> <p>Review of the MAR for Resident #1 for May and June 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There was a handwritten entry for Seroquel 200mg, take one tablet three times daily.</li> <li>-The scheduled administration times were 8:00am, 4:00pm, and 8:00pm.</li> <li>-Resident #1 received Seroquel 200mg three times daily from 05/01/16-05/31/16 and</li> </ul>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 101</p> <p>06/01/16-06/30/16 except from 05/24/16-05/30/16 when the medication notes documented the medication was "on order."</p> <p>Review of Resident #1's MAR for July 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There was a handwritten entry for Seroquel 200mg, ½ tablet twice daily for seven days.</li> <li>-The Seroquel was documented as administered from 07/01/16-07/07/16 at 8:00am and 8:00pm.</li> <li>-There was a second handwritten entry for Seroquel 200mg, one tablet twice daily for seven days.</li> <li>-The Seroquel was documented as administered from 07/08/16-07/14/16 at 8:00am and 8:00pm.</li> <li>-There was no entry on the MAR for Seroquel 100mg at bedtime for seven days.</li> </ul> <p>Review of pharmacy dispensing records revealed:</p> <ul style="list-style-type: none"> <li>-Ninety tablets of Seroquel 200mg were dispensed on 04/20/16.</li> <li>-Seventy tablets of Seroquel 200mg were dispensed on 05/25/15.</li> <li>-Ninety tablets of Seroquel 200mg were dispensed on 06/20/16.</li> </ul> <p>Review of faxed orders received from the pharmacy provider revealed the order for the Seroquel change on 01/14/16, 02/25/16, 04/20/16, and 06/29/16.</p> <p>Attempted interview with the mental health provider on 07/28/16 at 8:50 am revealed the mental health provider was out of town until 08/03/16 and the provider on duty was not familiar with Resident #1.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 330	<p>Continued From page 102</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>D. Review of physician orders for Resident #1 revealed: -There was an order for Vistaril (used to treat anxiety) 50mg at 8:00am, 4:00pm, and 8:00pm dated 02/25/16. -On 06/01/16, Vistaril 50mg, one capsule three times daily as needed was ordered.</p> <p>Review of Resident #1's MAR for June 2016 revealed: -There was a computer generated entry for Vistaril 50mg, take one capsule three times a day. -The scheduled times of administration were 8:00am, 4:00pm, and 8:00pm. -There was a second handwritten entry for Vistaril 50mg, take one capsule three times daily as needed for anxiety. -Resident #1 received Vistaril three times daily except for 06/14/16-06/16/16 due to the resident being hospitalized. -Resident #1 also received Vistaril as needed on 18 occasions from 06/01/16-06/30/16.</p> <p>Telephone interview with the pharmacy provider on 07/27/16 at 8:24am revealed: -The last order for Vistaril was received on 06/01/16 and it was for 50mg three times daily as needed. -There should not have been an entry on the MAR for routine Vistaril and as needed Vistaril. -Too much Vistaril could cause tremors.</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 103</p> <p>Review of an emergency department (ED) encounter dated 06/14/16 revealed:</p> <ul style="list-style-type: none"> <li>-The chief complaint was documented as tremors, resident had been withdrawn and tremulous for the past few days.</li> <li>-Resident #1 had uncontrollable shaking, confusion, and decreased interaction for three days.</li> <li>-The resident was admitted for dehydration and acute kidney injury.</li> </ul> <p>Attempted interview with the mental health provider on 07/28/16 at 8:50 am revealed the mental health provider was out of town until 08/03/16 and the provider on duty was not familiar with Resident #1.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>E. Review of an ED encounter dated 5/20/16 revealed:</p> <ul style="list-style-type: none"> <li>-The chief complaint was chronic back pain.</li> <li>-Resident #1 informed the ED physician that the staff had not been giving him his pain medication in over 2 months.</li> <li>-The "current outpatient prescriptions" for Resident #1 listed the following pain medications: Robaxin 500mg, take 1000mg four times daily (a muscle relaxant used to treat muscle spasms and pain), Naprosyn 500mg twice daily (an anti-inflammatory used to treat pain), Roxicodone 5mg every 6 hours as needed (a narcotic used to treat moderate-severe pain), and Lyrica 1000mg three times daily (a nerve pain medication).</li> </ul> <p>Review of physician's orders for Resident #1</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 330	<p>Continued From page 104</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-There was an order dated 02/02/16 for Robaxin 500mg 1-2 tablets every 6 hours.</li> <li>-On 03/24/16, an order was written for Naprosyn 500mg two times daily.</li> <li>-There was an order dated 04/17/16 for Roxicodone 5mg every 6 hours as needed for pain.</li> <li>-There was an order dated 05/10/16 revealed an order for Lyrica 100mg every 8 hours.</li> </ul> <p>Review of Resident #1's Medication Administration Record (MAR) for June 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There was a computer generated entry for Lyrica 100mg every eight hours.</li> <li>-The "nurses medication notes" on the MAR revealed that Lyrica was "out of stock" from 06/11/16-06/20/16.</li> <li>-There was a computer generated entry for Naprosyn 500mg, one tablet twice daily.</li> <li>-The "nurse's medication notes" documented the Naprosyn was "out of stock" from 06/01/16-06/03/16, 06/06/16, 06/09/16, and 06/14/16-06/17/16.</li> </ul> <p>Review of Resident #1's MAR for May 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There was a computer generated entry for Lyrica 100mg every eight hours.</li> <li>-Lyrica was documented as administered every eight hours from 05/01/16-05/31/16.</li> <li>-There was a computer generated entry for Robaxin 500mg, take 1-2 tablets every 6 hours.</li> <li>- There were no doses of Robaxin documented as administered and "d/c" was written beside the entry.</li> <li>-There was a computer generated entry for Roxicodone 5mg, take one tablet every 6 hours as needed for pain.</li> </ul>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 330	<p>Continued From page 105</p> <p>-There were no doses of Roxicodone documented as administered.</p> <p>Review of Resident #1's MAR for April 2016 revealed:</p> <p>-There was a handwritten entry for Roxicodone 5mg, take one every 6 hours as needed.</p> <p>-There was one dose of Roxicodone documented as administered on 04/21/16-04/24/16.</p> <p>-"Finished, d/c on 04/24/16" was handwritten beside the last dose administered.</p> <p>-There was a computer generated entry for Lyrica 100mg every eight hours.</p> <p>-Lyrica was documented as administered every eight hours from 04/04/16-04/30/16.</p> <p>-There was a computer generated entry for Robaxin 500mg, take 1 or 2 tablets every 6 hours.</p> <p>-Robaxin was documented as administered at 8:00am on 04/01/16-04/03/16.</p> <p>-"03/07/16, d/c" was handwritten beside the entry for Robaxin.</p> <p>Review of pharmacy dispensing records revealed:</p> <p>-On 02/03/16, 40 tablets of Robaxin were dispensed.</p> <p>-There were 30 tablets of Naprosyn dispensed on 03/25/16.</p> <p>-On 04/20/16, 6 tablets of Roxicodone were dispensed.</p> <p>-There were 87 tablets of Lyrica dispensed on 02/20/16.</p> <p>-On 03/20/16, 93 tablets of Lyrica was dispensed.</p> <p>-Ninety tablets of Lyrica 100mg were dispensed on 4/20/16.</p> <p>-There were 31 tablets of Lyrica dispensed on 5/20/16.</p> <p>-On 6/20/16, there were 90 tablets of Lyrica dispensed.</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 106</p> <p>Telephone interview with the pharmacist on 07/27/16 at 8:24am revealed:                      -There had been no prescription for Naprosyn since 03/24/16.                      -The Lyrica should not have been out of stock, because it was dispensed around every 30 days.                      -There had been no new prescription for Robaxin; it was filled on 02/03/16 and no refills were ordered on the prescription.                      -The facility should be calling the physician if a resident needs a new prescription or refill.                      -The pharmacist would call for a refill if the facility requested.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>2. Review of Resident #2's current FL2 dated 05/2/16 revealed:                      -Diagnoses included schizoaffective disorder, intellectual disability-moderate, dyspepsia, diabetes mellitus type 2.                      -There was no order for finger stick blood sugar checks.</p> <p>A. Review of a physician order on the FL2 dated 05/02/16 revealed an order for Metformin (an antidiabetic used to treat diabetes) 500mg every morning.</p> <p>Review of Resident #2's Medication Administration Record (MAR) for May 2016 revealed:</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 330	<p>Continued From page 107</p> <ul style="list-style-type: none"> <li>-There was a handwritten entry for Metformin 500mg, take one tablet at breakfast</li> <li>-The Metformin was scheduled to be administered at 8:00am.</li> <li>-There were no initials documenting that the Metformin was administered on 05/03/16, 05/04/16, or 05/06/16.</li> <li>-There was no documentation on the "nurse's medication notes" on the back of the MAR as to why the Metformin was not administered or that the physician was notified.</li> </ul> <p>Refer to interview with a staff on 07/14/16 at 8:10am.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Supervisor-in-Charge (SIC) on 07/18/16 at 4:35pm.</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>B. Review of a physician's order on the FL2 dated 05/02/16 revealed an order for Geodon (an antipsychotic used to treat schizophrenia) 20mg every morning and 40mg with dinner.</p> <p>Review of Resident #2's MAR for May 2016 revealed:</p> <ul style="list-style-type: none"> <li>-There was a handwritten entry for Geodon 20mg, take one capsule every day with breakfast.</li> <li>-The Geodon was scheduled to be administered at 8:00am.</li> <li>-There was a second handwritten entry for</li> </ul>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 108</p> <p>Geodon 40mg, take one capsule every day before dinner/supper. -The Geodon was scheduled to be administered at 3:00pm and 8:00pm. -Resident #2 was administered Geodon every day, three times a day, at 8:00am, 3:00pm, and 8:00pm except on 05/16/16, 05/17/16, and 05/18/16 when Resident #2 was documented as being out of the facility.</p> <p>Review of a physician's order dated 05/31/16 revealed an order for Geodon 80 mg, take one tablet every morning and every evening with supper.</p> <p>Review of Resident #2's MAR for June 2016 revealed: -There was a handwritten entry for Geodon 80mg, take one tablet every morning and one tablet with dinner. -The scheduled times of administration were 8:00am and 5:00pm. -From 06/07/16-6/20/16, Resident #2 was not administered the Geodon for a total of 26 doses. -The documentation on the "nurse's medication notes" revealed the medication was not given because "med makes her sick" and "med makes her sleepy." -There was no documentation that the physician was notified of the Geodon not being given from 06/07/16-06/20/16.</p> <p>Interview with a staff on 07/14/16 at 8:10am revealed -The Geodon was not given to Resident #2 because it made her sleepy and she would stagger when she walked. -The Supervisor-In-Charge (SIC) was aware that Resident #2 was refusing the Geodon.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 330	<p>Continued From page 109</p> <p>Interview with the SIC on 07/14/16 at 11:00am revealed:</p> <ul style="list-style-type: none"> <li>-Resident #2 was supposed to go to a mental health appointment, but the appointment was rescheduled to 06/29/16, because the physician was not going to be there until then.</li> <li>-The nurse "was calling me in a one month supply for Geodon 80mg to the pharmacy."</li> <li>-"I never got the order, because it was called in to the pharmacy."</li> </ul> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>Attempted interview with the mental health provider on 07/28/16 at 8:50 am revealed the mental health provider was out of town until 08/03/16 and the provider on duty was not familiar with Resident #2.</p> <p>C. Review of physician orders for Resident #2 dated 05/13/16 received from the pharmacy revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for Flagyl (an antibiotic used to treat vaginal infections) 500mg twice daily for seven days.</li> <li>-There was an order for Diflucan (an antifungal) 150mg, one tablet every other day for 3 doses.</li> <li>-The orders were received by the pharmacy on 05/20/16.</li> </ul> <p>Review of the facility's staff communication notes revealed:</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 110</p> <p>-On 05/19/16 and 05/20/16, Resident #2 complaining "about her vaginal (sic) and passing discharge."</p> <p>-On 05/30/16, Resident #2 complained to staff about "passing discharge and it had an odor; I let SIC (Supervisor-in-Charge) know."</p> <p>Review of the "Patient Chart Report" from Resident #2's primary provider dated 05/13/16 revealed:</p> <p>-Resident #2 complained of vaginal burning and thick discharge for the past 4 weeks.</p> <p>-A vaginal wet mount smear was positive for bacteria and candida (a yeast or fungal infection).</p> <p>Review of Resident #2's MAR for May 2016 revealed:</p> <p>-There was a handwritten entry for Flagyl 500mg, take one tablet twice daily for seven days.</p> <p>-There was a second handwritten entry for Diflucan 150mg, take one tablet every other day for three days, then discontinue.</p> <p>-The first dose of Flagyl was documented as administered on 05/23/16.</p> <p>-The first dose of Diflucan was documented as administered on 05/21/16.</p> <p>Review of the pharmacy dispensing records revealed the dispense date for the Flagyl and Diflucan was 05/20/16.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to the telephone interview with the SIC on 07/18/16 at 4:35pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 111</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>D. Review of a physician order on the FL2 dated 05/02/16 revealed an order for Pepcid (an antiulcer) 20mg twice daily.</p> <p>Review of Resident #2's MAR for June 2016 revealed: -There was a handwritten entry for Pepcid 20mg, one tablet twice daily. -From 06/24/16-06/30/16, Pepcid was documented as not administered to Resident #2. -The medication notes documented that the medication was "on order." -There was no documentation that the physician was aware that 14 doses of Pepcid was not given.</p> <p>Review of the pharmacy dispensing records revealed: -On 05/23/16, fifty six tablets of Pepcid were dispensed. -Forty tablets were dispensed on 06/30/16.</p> <p>Observation of medications on hand on 07/14/16 at 10:50am revealed there were 7 tablets of Pepcid on hand in one bubble pack and 8 tablets in a second bubble pack both with a dispense date of 06/30/16.</p> <p>Refer to interview with a staff on 07/14/16 at 8:10am.</p> <p>Telephone interview with the pharmacy provider on 07/27/16 at 8:24am revealed: -Fifty six tablets of Pepcid was dispensed on 05/23/16. -There were twenty days remaining on the cycle,</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 112</p> <p>so only 40 were dispensed on 06/30/16.</p> <p>-Pepcid was a batched medication and was dispensed again on the cycle date of 07/20/16.</p> <p>-If the facility was getting low on a medication, the staff should contact the pharmacy.</p> <p>-Batch refills get filled automatically on a cycle, but as needed medications were the staff's responsibility; they had to contact the pharmacy for an as needed medication, so that the medication could be sent to the facility.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>E. Review of a physician's order dated 06/29/16 revealed an order for Saphris (an antipsychotic used to treat schizophrenia) 5mg, one tablet at bedtime.</p> <p>Review of a handwritten request signed by Supervisor-In-Charge (SIC) on 07/14/16 revealed:</p> <p>-There was a request that read "still have not receive [Resident #2's name] Saphris 5mg. I have fax and fax since 06/29/16. I need her meds."</p> <p>-There was no date on the request, nor was there evidence the request was faxed or to who it was faxed to.</p> <p>Interview with the SIC on 07/14/16 at 9:50am revealed:</p> <p>-The SIC had been faxing a prescription for Saphris to the pharmacy since June.</p> <p>-The medication had not been sent to the facility.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 330	<p>Continued From page 113</p> <p>Telephone interview with the pharmacy provider on 07/27/16 on 8:24am revealed: -Saphris was filled on 07/14/16. -The pharmacy did not receive the prescription until 07/14/16 at 9:13am.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 7/18/16 at 1:55pm.</p> <p>Attempted interview with the mental health provider on 07/28/16 at 8:50 am revealed the mental health provider was out of town until 08/03/16 and the provider on duty was not familiar with Resident #2.</p> <p>3. Review of Resident #3's current FL-2 dated 06/08/16 revealed: -Diagnoses included schizophrenia, depression, hypertension, and type 2 diabetes. -The admission date to the facility was documented as 04/13/16. -There was a medication order for probiotic capsule, take one daily.</p> <p>A. Review of an appointment encounter for Resident #3 dated 06/08/16 revealed: -Resident #3 was evaluated by the PA on 06/08/16. -Resident #3 had loose stools. -Under the "assessment" section there was documentation which read "loose stools most likely from Metformin." -Under the "plan" section there was</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 114</p> <p>documentation which read "Probiotic caps, 1 daily ..."</p> <p>Review of Resident #3's June 2016 MARS revealed: -The MAR was handwritten. -There was no entry for the probiotic transcribed onto the MAR. -There was no documentation Resident #3 received the probiotic in June 2016.</p> <p>Review of Resident #3's July 2016 MARS revealed: -There was no entry for the probiotic on the MAR. -There was no documentation Resident #3 received the probiotic in July 2016.</p> <p>Review of the Drug Regimen Review for Resident #3 dated 06/24/16 completed by the Registered nurse (RN) revealed: -Resident #3's FL-s and MAR did not match. -"No probiotic caps in cart." -"Place order for probiotic caps."</p> <p>Review of the medications on hand on 07/14/16 at 10:50am revealed there were no Probiotic capsules on the cart.</p> <p>Telephone interview with the RN on 07/14/16 at 11:24am revealed there was no order for the Probiotic transcribed onto the MAR and the medication was not available on the cart when the drug review was completed on 06/24/16.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/26/16 at 1:55pm revealed Resident #3's FL-2 dated 06/08/16 with the probiotic order was not on file at the pharmacy.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 330	<p>Continued From page 115</p> <p>Review of the pharmacy dispensing records for Resident #3 from 01/01/16-07/15/16 revealed the pharmacy had never dispensed any probiotic capsules for Resident #3.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Refer to telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm.</p> <p>B. Review of a Clinical Summary for Resident #3 dated 04/05/16 revealed Resident #3 was evaluated by the PA for heartburn.</p> <p>Review of the physician order's for Resident #3 provided by the contracted pharmacy revealed: -There was an order for Pantoprazole 40mg, take one daily dated 04/05/16. (Pantoprazole is a medication used to treat the symptoms of gastroesophageal reflux by decreasing the amount of acid produced by the stomach). -There was an order to discontinue Pantoprazole dated 04/21/16. -There was an order for Omeprazole 20mg. daily dated 04/21/16. (Omeprazole is another medication used to treat gastroesophageal reflux by decreasing the amount of acid produced by the stomach).</p> <p>Review of Resident #3's April 2016 MARs revealed: -There was a handwritten entry for Pantoprazole 40mg, one daily with an administration time of 08:00am. -There was documentation Resident #3 was administered Pantoprazole 40mg. from</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 116</p> <p>04/14/16-04/26/16, and 04/29/16-04/30/16. -There was documentation Pantoprazole was "out of stock" and not administered to Resident #3 on 04/27/16 and 04/28/16.</p> <p>Review of Resident #3's May 2016 MARs revealed: -There was a handwritten entry for Pantoprazole 40mg, one daily with an administration time of 08:00am. -There was documentation Resident #3 was administered Pantoprazole 40mg daily at 08:00am from 05/01/16-05/30/16; Pantoprazole was documented as "out of stock" on 05/31/16 and not administered. -There was a handwritten entry for omeprazole 20mg, take in every day with administration time of 08:00am. -There was documentation Resident #3 was administered Omeprazole 20mg daily at 08:00am from 05/04/16-05/31/16.</p> <p>Review of Resident #3's June 2016 MARs revealed: -There were two different handwritten entries for Pantoprazole 40mg, one daily with an administration time of 08:00am. -Beside the first Pantoprazole entry, there were staff initials documenting Resident #3 was administered Pantoprazole 40mg daily at 08:00am from 06/01/16-06/03/16, but the initials were marked through and "D/C 06/08/16" was written beside the entry. -Beside the first entry, staff circled their initials from 06/04/16-06/10/16; on the back of the MAR, Pantoprazole was documented as "on order" and not given. -Beside the second Pantoprazole entry, "D/C" was handwritten but there was documentation Pantoprazole was administered to Resident #3 on</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 117</p> <p>06/18/16 and 06/19/16; staff circled their initials from 06/20/16-06/24/16 Pantoprazole was documented as "out of stock" and not administered.</p> <p>Review of Resident #3's record revealed: -There was no order found in the record for Omeprazole except on an old FL-2 dated 02/08/16. -There was no order found to discontinue Pantoprazole.</p> <p>Review of Resident #3's July 2016 MARs revealed: -There was a preprinted entry for Omeprazole 20mg, take one daily with administration time of 08:00am. -Omeprazole was documented as administered to Resident #3 from 07/01/16-07/14/16.</p> <p>Interview with Resident #3 on 07/28/16 at 6:40am revealed he did not know if he got his medications like he was supposed to.</p> <p>Refer to telephone interview with the pharmacist on 07/14/16 at 12:10pm.</p> <p>Refer to interview with the Administrator on 07/14/16 at 12:45pm.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 07/26/16 at 1:55pm revealed: -The most up to date FL-2 on file for Resident #3 at the pharmacy was dated 02/08/16. -The pharmacy had two FL-2s on file for Resident #3 dated 02/08/16. -The pharmacy received the FL-2 dated 2/8/16 on 2/8/16 and Omeprazole was not listed as an order.</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 330	<p>Continued From page 118</p> <ul style="list-style-type: none"> <li>-The pharmacy received the second FL-2 dated 2/8/15 on 5/31/16 and it had a medication order for Omeprazole listed.</li> <li>-Resident #3 should not have received Omeprazole and Protonix concurrently.</li> </ul> <p>_____</p> <p>Interview with a staff on 07/14/16 at 8:10am revealed:</p> <ul style="list-style-type: none"> <li>-The SIC was responsible for letting the physician know if a resident refused medications or if a medication was not administered.</li> <li>-The staff would report to the SIC if a medication was refused or not given, then the SIC would follow-up.</li> <li>-If a medication was out of stock, the SIC ordered the refill.</li> </ul> <p>Telephone interview with the pharmacist on 07/14/16 at 12:10pm revealed:</p> <ul style="list-style-type: none"> <li>-All medications on "cycle fill" were dispensed on the 20th of each month.</li> <li>-The facility was responsible for faxing orders to the pharmacy and updated the MAR after the pharmacy printed the MAR if anything changed.</li> <li>-If an order needed to be clarified, the pharmacy would call the facility first to try to get an answer, and if no response from the facility, the pharmacy would then call or fax the provider.</li> <li>-The pharmacy would notify the facility if changes were received by the provider to ensure that the facility was aware of any changes or new orders.</li> <li>-MARS were generated by the pharmacy each month on the 25th for the next month.</li> <li>-The facility was responsible for assuring that orders received after the MARs were printed were changed on the current MAR.</li> </ul> <p>Telephone interview with the SIC on 07/18/16 at 4:35pm revealed:</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 119</p> <ul style="list-style-type: none"> <li>-If residents refuse medications, the SIC was responsible for calling the physician and making an appointment.</li> <li>-The SIC usually waited "a couple of days" and then call the physician if a resident started refusing medications.</li> <li>-There was a folder in the SIC's car with all physician orders and the SIC would fax them when she got to a fax machine, since there was no fax machine in the facility.</li> <li>-That could have caused a delay in the residents getting their medications.</li> </ul> <p>Interview with the Administrator on 07/14/16 at 12:45pm revealed the SIC was responsible for assuring orders were faxed to the pharmacy and transcribing new orders to the MAR.</p> <p>Telephone interview with the Physician Assistant (PA) on 07/18/16 at 1:55pm revealed:</p> <ul style="list-style-type: none"> <li>-He expected the residents to receive all medications as ordered.</li> <li>-He had not been notified by the facility of any medication errors.</li> <li>-He expected to be contacted with any issues concerning medication administration and medication errors.</li> </ul> <hr/> <p>The facility's failure to administer an antibiotic as ordered on 04/26/16 and 04/28/16 to Resident # 1, who had an abscess that required packing twice, and delayed starting the antibiotic after a second physician visit on 04/28/2016. The errors in Resident #1 receiving ordered pain medications (Lyrica, Roxicodone, Robaxin, and Naprosyn) in April, May, June, and July 2016, resulted in Resident #1 being taken to the emergency room for back pain. On 05/13/16, the physician prescribed Flagyl and Diflucan to</p>	C 330		

Division of Health Service Regulation

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C 330	<p>Continued From page 120</p> <p>Resident #2 after being diagnosed with vaginal infection. Again, there was a delay with the initiation of the medications ordered for Resident #2, the first dose of Diflucan was not administered until 05/21/16 and the first dose of Flagyl until 05/23/16. The facility failed to have a system in place to ensure medications were administered as ordered resulting in antipsychotics and medication for diabetes not being administered as ordered. The facility's failure to administer medication as ordered, especially for Resident # 1, resulted in serious neglect. This is a Type A1 Violation.</p> <hr/> <p>Review of the Plan of Protection submitted by the facility dated 07/28/16 revealed: -Administrator will follow up with doctor's office to follow up with medication changes and make sure the FL2 plans are matching the Medication Administration Record (MAR) and new orders/medication changes. -Administrator will monitor MAR once a week and also the SIC will follow up with MAR books.</p> <p>THE CORRECTION DATE OF THIS TYPE A1 VIOLATION SHALL NOT EXCEED 08/27/16.</p>	C 330		
C 381	<p>10A NCAC 13G .1009(b) Pharmaceutical Care</p> <p>10A NCAC 13G .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and documented, including that the physician or appropriate health professional has been informed of the findings when necessary.</p> <p>This Rule is not met as evidenced by:</p>	C 381		

Division of Health Service Regulation

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C 381	<p>Continued From page 121</p> <p>Based on record review and interview, the facility failed to act upon 3 of 5 recommendations related to recommendations for ensuring that all new and discontinued medications have an order in the record (#1, #2), the Medication Administration Record (MAR) included all ordered medications and the ordered medications were available on the medication cart (#3). The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 11/23/15 revealed diagnoses included major depressive disorder, hypertension, diabetes, chronic obstructive pulmonary disease, and hepatitis C.</p> <p>Review of the Drug Regimen Review recommendations for June 2016 from the Registered Nurse (RN) revealed: -The orders on the FL2 dated 11/23/15 did not match the MAR. -The facility needed to ensure that all new medications and discontinued medications have an order in the resident's record. -Order Naprosyn and Robaxin. -Clarify orders that state one to two tablets (must be one or the other.)</p> <p>Review of physician orders provided by the pharmacy on 7/15/16 that were not in Resident #1's record at the facility revealed: -There was an order dated 2/10/16 for Miralax 17grams, take one capful mixed with 16 ounces of water daily. -There was an order dated 4/15/16 for Protonix 40mg twice daily before breakfast and supper. -There was an order dated 4/20/16 to discontinue Seroquel. -There was an order dated 4/28/16 for Clindamycin 300mg four times daily for seven days.</p>	C 381		

Division of Health Service Regulation

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C 381	<p>Continued From page 122</p> <ul style="list-style-type: none"> <li>-There was an order dated 6/1/16 for Risperdal 2mg, take one tab twice daily.</li> <li>-There was an order dated 6/29/16 for Hydroxyzine 15mg three times daily.</li> </ul> <p>Review of physician orders in Resident #1's record revealed:</p> <ul style="list-style-type: none"> <li>-There were no new orders for Naprosyn or Robaxin.</li> <li>-There was no clarification of Robaxin one to two tablets.</li> </ul> <p>Review of the July2016 Medication Administration Record (MAR) for Resident #1 revealed:</p> <ul style="list-style-type: none"> <li>-There was a computer generated entry for Naprosyn 500mg, take one tablet twice daily.</li> <li>-There were no initials indicating that Naprosyn had been administered.</li> <li>-Beside the entry for Naprosyn on the MAR, "d/c" was written.</li> <li>-There was a second computer generated entry for Robaxin 500mg, take one or two tablets every 6 hours.</li> <li>-There were no initials indicating that Robaxin had been administered.</li> <li>-Beside the entry for Robaxin, "d/c" was written.</li> </ul> <p>Telephone interview with the RN on 7/14/16 at 11:24am revealed that Resident #1 had medications on the cart and the MAR that had been discontinued.</p> <p>Refer to telephone interview with the RN on 7/14/16 at 11:24am.</p> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>2. Review of Resident #2's current FL2 dated</p>	C 381		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 381	<p>Continued From page 123</p> <p>5/2/16 revealed diagnoses included schizoaffective disorder, intellectual disability-moderate, dyspepsia, diabetes mellitus type 2.</p> <p>Review of the Drug Regimen Review recommendations for June 2016 from the Registered Nurse (RN) revealed the facility needed to ensure that all new medications and discontinued medications have an order in the resident's record.</p> <p>Review of a physician's order dated 6/29/16 provided by the Supervisor-in-Charge (SIC) on 7/14/16 at 9:50am revealed:</p> <ul style="list-style-type: none"> <li>-There was an order for Saphris 5mg, one tablet at bedtime.</li> <li>-There was an order to discontinue Geodon and Tegretol.</li> <li>-There was an order for Luvox 100mg, 1 ½ tablet at bedtime.</li> <li>-There was an order to change Vistaril 50mg to one tablet at bedtime.</li> <li>-There was an order to decrease Cogentin to 1mg, one tablet at bedtime.</li> <li>-There was an order for Depakote DR 250mg, one tablet in the morning and two tablets at bedtime.</li> </ul> <p>Review of physician orders provided by the pharmacy on 7/15/16 that were not in Resident #2's record at the facility revealed:</p> <ul style="list-style-type: none"> <li>-There was an order dated 4/29/16 for Atarax 10mg, take one tablet every six hours as needed for anxiety.</li> <li>-There was an order dated 4/29/16 for Geodon 40mg, take one capsule daily before dinner and 20mg, take one capsule daily with breakfast.</li> <li>-There was an order dated 5/13/16 for Flagyl 500mg twice daily for 7 days.</li> <li>-There was an order dated 5/13/16 for Diflucan</li> </ul>	C 381		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 381	<p>Continued From page 124</p> <p>150mg every other day times 3 doses.</p> <p>Telephone interview with the RN on 7/14/16 at 11:24am revealed there were "a lot of problems" with findings orders for Resident #2 and there was no Metformin on the cart.</p> <p>Refer to telephone interview with the RN on 7/14/16 at 11:24am.</p> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>3. Review of Resident #3's current FL-2 dated 06/08/16 revealed: -Diagnoses included schizophrenia, depression, hypertension, and type 2 diabetes. -Resident #3 was intermittently disoriented. -The admission date to the facility was documented as 04/13/16.</p> <p>Review of the Drug Regimen Review recommendations for June 2016 from the Registered Nurse (RN) revealed: -The current FL2 dated 6/8/16 and the MAR did not match. -There was an order dated 6/8/16 for Probiotic capsules, take one daily that was not on the MAR. -There were no Probiotic capsules on the medication cart.</p> <p>Review of the medications on hand on 7/14/16 at 10:50am revealed there were no Probiotic capsules on the cart.</p> <p>Telephone interview with the RN on 7/14/16 at 11:24am revealed there was no order for the Probiotic transcribed onto the MAR and the medication was not available on the cart.</p>	C 381		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 381	<p>Continued From page 125</p> <p>Refer to telephone interview with the RN on 7/14/16 at 11:24am.</p> <p>Refer to interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm.</p> <p>_____ Telephone interview with the Registered Nurse (RN) on 7/14/16 at 11:24am revealed:</p> <ul style="list-style-type: none"> <li>-There were orders on the MAR that she could not locate in the records for "almost every resident."</li> <li>-"It was a mess."</li> <li>-The RN met with the Administrator about the problems with orders not being in the records and the RN's concerns about medications not being available on the medication cart.</li> <li>-Several medications were missing and it was noted on the MAR "please order."</li> <li>-The Administrator told the RN that there were orders that "may not be filed in the records yet."</li> <li>-The Administrator could not locate orders for some medications that were on the MAR.</li> <li>-The RN told the Administrator that the medications had been sent from the pharmacy, so there must have been some kind of an order for the medications to have been in the facility.</li> </ul> <p>Interview with the Supervisor-in-Charge on 7/18/16 at 12:00pm revealed:</p> <ul style="list-style-type: none"> <li>-The SIC kept the paper work, orders, and progress notes from medical appointments in her car in a notebook.</li> <li>-She kept the information in her notebook until she could get back from the appointments and go to another facility to fax the orders to the pharmacy.</li> </ul>	C 381		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 448	Continued From page 126	C 448		
C 448	<p>10A NCAC 13G .1213 (e) Reporting Of Accidents And Incidents</p> <p>10A NCAC 13G .1213 Reporting Of Accidents And Incidents</p> <p>(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:</p> <p>(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the responsible person or contact person of 2 of 2 residents sampled (#5, #6) of incidents of injury or illness requiring hospital medical treatment and hospitalization.</p> <p>The findings are:</p> <p>1. Review of Resident #5's FL-2 dated 05/16/16 revealed: -Diagnoses included schizoaffective disorder, Tourette's syndrome, and autism spectrum disorder. -Resident #5 was intermittently disoriented. -Resident #5 was a wanderer and was verbally abusive.</p>	C 448		

Division of Health Service Regulation

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C 448	<p>Continued From page 127</p> <p>Review Resident #5's Care Plan dated 05/16/16 revealed: -Resident #5 had a history of developmental disabilities, mental illness, and wandering. -The care plan was signed by Resident #5's health care provider and dated 05/16/16.</p> <p>Review of Resident #5's record revealed a notice of a court appointed guardian dated 12/16/14.</p> <p>Review of the hospital discharge summary from an inpatient psychiatric hospital dated 05/06/16 revealed Resident #5 was admitted on 04/26/16 and discharged on 05/06/16.</p> <p>Review on an Incident Report dated 1/24/16 revealed: -Resident #2 was complaining about Resident #5 coming into her room at night. -Resident #2 reported that Resident #5 came into her room "wanting to have sex." -Resident #2 told Resident #5 "no." -Resident #5 would walk into Resident #2's room with no clothes on. -Resident #2 reported "wanting to get away from [Resident #5's name]."</p> <p>Review of a second incident report dated 5/12/16 revealed: -Resident #2 called the mental health clinic without the staff at the facility's knowledge, and reported being "raped" by Resident #5 "a month ago." -The mental health clinic called 911 and a detective went to the facility and took reports from Resident #2 and #5.</p> <p>Telephone interview with Resident #5's guardian on 07/26/16 at 1:02pm revealed: -Resident #5 was admitted into the hospital in</p>	C 448		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 448	<p>Continued From page 128</p> <p>April 2016 and the facility failed to notify the guardian "until days after." -The guardian was kept "uniformed about so many things" by the facility. -Resident #5 had "meltdowns and would be sent to the hospital; the facility did not notify the guardian until "days after: " -The facility never notified or updated the guardian on Resident #5's behaviors that required hospitalization. -The guardian was never notified by the facility of any incidents between Resident #5 and Resident #2 until Resident #5 "was charged by police." -The guardian "never knew it was going on;" staff at the facility should have called the guardian.</p> <p>Refer to interview with the Supervisor-in-Charge (SIC) on 7/18/16 at 12:00pm.</p> <p>2. Review of Resident #6's FL2 dated 9/22/15 revealed diagnoses included schizoaffective disorder, cocaine use disorder-severe, and cannabis use disorder-severe.</p> <p>Review of Resident #6's Resident Register revealed: -Resident #6 was admitted to the facility on 2/17/14. -She was discharged on 11/10/15.</p> <p>Review of the staff communication notes for Resident #6 revealed from 6/28/15- 10/31/15, Resident #6's was documented as signing out of the facility 34 times.</p> <p>Review of an Emergency Department Encounter dated 8/29/15 revealed: -Resident #6 was seen for right eye pain and bruising for three days. -She reported being in a fight with a man at that</p>	C 448		

Division of Health Service Regulation

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C 448	<p>Continued From page 129</p> <p>time and was punched multiple times in the head and her body.</p> <p>Review of a second emergency department encounter dated 9/15/15 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #6 was seen for an intentional overdose of muscle relaxers.</li> <li>-She reported suicidal thoughts and also having attempted to cut her left wrist with a key earlier in the day on 9/15/15.</li> <li>-Resident #6 reported to the physician that she was a prostitute and had smoked two grams of crack the night before, on 9/14/15.</li> <li>-Upon examination, the physician noted superficial abrasions to Resident #6's left wrist.</li> <li>-Urine drug screen results revealed Resident #6 tested positive for marijuana and cocaine use.</li> <li>-Resident #6 was discharged in the sheriff department's care under involuntary commitment to be transported to a behavioral health hospital.</li> </ul> <p>Review of the facility's incident reports revealed there were no incident reports related to Resident #6.</p> <p>Telephone interview with Resident #6's family member on 7/28/16 at 2:08pm revealed:</p> <ul style="list-style-type: none"> <li>-The family member had never visited the facility.</li> <li>-Resident #6's care had been released to another family member.</li> <li>-The family member knew that Resident #6 would go stay off with friends.</li> <li>-Resident #6 had a problem with suicide attempts and had been hospitalized once for taking a bunch of medication.</li> </ul> <p>Telephone interview with a second family member for Resident #6 at 7/28/16 at 5:30pm revealed:</p> <ul style="list-style-type: none"> <li>-The family member had visited the facility a few times.</li> </ul>	C 448		

Division of Health Service Regulation

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C 448	<p>Continued From page 130</p> <ul style="list-style-type: none"> <li>-Resident #6 would be at places she should not have been.</li> <li>-There were times when there was no staff at the facility with the residents.</li> <li>-Resident #6 would leave and go stay with people she did not know.</li> <li>-The staff at the facility could never tell the family member where Resident #6 was or who she was with.</li> <li>-She had called the family member one morning (could not remember the date) and told the family member that she had been raped.</li> <li>-The family member was called after the rape by Resident #6 because Resident #6 reported taking a whole bottle of medication.</li> <li>-Resident #6 had made suicide attempts in the past and had a problem with street drugs.</li> <li>-The family member would "threaten" the staff about not supervising the residents or not knowing where they were, and the staff would "suddenly have found" Resident #6.</li> </ul> <p>Telephone interview with Resident #6 revealed:</p> <ul style="list-style-type: none"> <li>-She would sign out and let the staff know she would be with friends.</li> <li>-She was hospitalized once around this time last year because she tried to commit suicide.</li> <li>-"He raped me and the next night, I tried to kill myself. A friend gave me eighty muscle relaxers."</li> <li>-This was the seventh time Resident #6 had tried to kill herself.</li> <li>-The person who raped her was someone she met at the local store, and he got the wrong impression.</li> <li>-Resident #6 was held at gunpoint in a cornfield.</li> <li>-She did not tell anyone right away, because the gun was stolen from drug dealers and she was afraid she would be hurt badly if she told.</li> <li>-The resident was using drugs at the time of the rape.</li> </ul>	C 448		
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Division of Health Service Regulation

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C 448	<p>Continued From page 131</p> <p>-She told a detective what had happened, but because she waited several days to make a report, the detective could not gather any evidence.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 7/28/16 at 4:10pm revealed:</p> <p>-Resident #6 was her own guardian and would sign herself out.</p> <p>-Resident #6 did not follow facility policy which was why she left the facility.</p> <p>-There were times when Resident #6 would be gone for two days, but staff always knew where she was because Resident #6 would call.</p> <p>-The SIC did not know if Resident #6 ever tried to kill herself.</p> <p>-Resident #6 would be with guys and would say they would rape her.</p> <p>-The SIC had never seen Resident #6 abusing drugs, but she had heard that Resident #6 had a drug problem.</p> <p>-The SIC did not know where Resident #6 got drugs from.</p> <p>-The only time staff could tell if Resident #6 was "on something" was when she was drinking, but Resident #6 never bought alcohol to the facility.</p> <p>-The SIC thought Resident #6 got money from being a prostitute.</p> <p>-The SIC recalled Resident #6 being beaten up, but the SIC was not working at the facility at the time; "I think it was her eye."</p> <p>Interview with the Administrator on 7/28/16 at 4:40pm revealed:</p> <p>-She still talked with Resident #6.</p> <p>-Resident #6 was a prostitute when she came to live at the facility.</p> <p>-"I had told them it was dangerous to be out late at night."</p>	C 448		

Division of Health Service Regulation

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C 448	Continued From page 132  Refer to interview with the Supervisor-in-Charge (SIC) on 7/18/16 at 12:00pm.  _____  Interview with the SIC on 7/18/16 at 12:00pm revealed: -Another staff was doing incident reports, but she was only writing them down on paper. -The reports were not being send to the Department of Social Services, and the physician nor family was being notified.	C 448		
C 911	G.S 131D 21(1) Declaration of Resident's Rights  G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: (1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to treat all residents with respect, consideration, and dignity as it relates to allowing residents to make choices about attending a day program, providing second helpings at meals, building service equipment, personal care and supervision, health care, and talking to residents in a disrespectful manner. The findings are:  1. Based on observation and interview, the facility failed to assure all plumbing equipment in the facility was maintained in a safe and operating condition as related to the water pump providing adequate water for residents' showers. [Refer to Tag C0102 10A NCAC 13G. 0317(a) Building Service Equipment (TYPE B VIOLATION)].	C 911		

Division of Health Service Regulation

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C 911	<p>Continued From page 133</p> <p>2. Based on record reviews and interviews, the facility failed to assure that 4 of 6 residents sampled (#1, #2, #4, #5) went to appointments with their medical and mental health providers resulting in Resident #1 developing infection from a surgical procedure; and, failed to notify the health care provider or seek emergency treatment for 3 of 6 residents sampled (#1, #2, #3) who had requested physician visits for pain (#1) and allegations of being raped (#2) and who had refused blood pressure medication (#3). [Refer to Tag C0246 10A NCAC 13G. 0902(b) Health Care (TYPE A1 VIOLATION)].</p> <p>3. Based on observations and interviews the facility failed to assure 4 of 4 residents sampled (#1, #2, #3, #4) were treated with respect, consideration and dignity as evidenced not allowing residents to have a second helping at meals, staff talking to residents in a disrespectful manner, and not allowing residents the choice of attending a psychosocial (PSR) day program resulting in a violation of the residents' rights. [Refer to Tag C311 10A NCAC 13G. 0909 Residents' Rights (TYPE B VIOLATION)].</p>	C 911		
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> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record</p>	C 912		

Division of Health Service Regulation

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C 912	<p>Continued From page 134</p> <p>reviews, the facility failed to ensure residents received the care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations as it relates to housekeeping and furnishings, fire safety and disaster plan, building service equipment, personal care and supervision, health care, other resident services which included transportation and medication administration. The findings are:</p> <p>1. Based on observations and interviews, the facility failed to assure the walls were clean and in good repair in 3 of 3 resident bedrooms, the common resident bathroom, living room and hallway, and the ceiling was in clean and in good repair in the living room and bathroom, and the floors were clean and in good repair in the 2 of 3 resident bedrooms, the common bathroom, and the kitchen. [Refer to Tag C0074 10A NCAC 13G. 0315(a)(1) Housekeeping and Furnishings (TYPE B VIOLATION)].</p> <p>2. Based on observations and interviews, the facility failed to assure the facility bathroom, kitchen, living room, 3 of 3 resident bedrooms, and outside grounds were kept clean, uncluttered, and free of hazards. [Refer to Tag C0078 10A NCAC 13G. 0315(a)(5) Housekeeping and Furnishings (TYPE B VIOLATION)].</p> <p>3. Based on interviews, record reviews, and observations, the facility failed to replace the batteries in one smoke detector in order to maintain a working fire alarm system. [Refer to Tag C0097 10A NCAC 13G. 0316(b) Fire Safety and Disaster Plan (TYPE B VIOLATION)].</p>	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GREEN ACRES FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8461 PINEY WOODS ROAD</b> <b>WATHA, NC 28471</b>
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C 912	<p>Continued From page 135</p> <p>4. Based on observations, record reviews, and interviews, the facility failed to assure fire drills were completed quarterly in 2015 and 2016. [Refer to Tag C0100 10A NCAC 13G. 0316(e) Fire Safety and Disaster Plan (TYPE B VIOLATION)].</p> <p>5. Based on observation and interview, the facility failed to assure all plumbing equipment in the facility was maintained in a safe and operating condition as related to the water pump providing adequate water for residents' showers. [Refer to Tag C0102 10A NCAC 13G. 0317(a) Building Service Equipment (TYPE B VIOLATION)].</p> <p>6. Based on record reviews and interviews, the facility failed to assure that 4 of 6 residents sampled (#1, #2, #4, #5) went to appointments with their medical and mental health providers resulting in Resident #1 developing infection from a surgical procedure; and, failed to notify the health care provider or seek emergency treatment for 3 of 6 residents sampled (#1, #2, #3) who had requested physician visits for pain (#1) and allegations of being raped (#2) and who had refused blood pressure medication (#3). [Refer to Tag C0246 10A NCAC 13G. 0902(b) Health Care (TYPE A1 VIOLATION)].</p> <p>7. Based on observations, interviews, and record reviews, the facility failed to assure the provision of transportation for the residents to and from the hospital, emergency room, medical appointments, and the day program for all the residents who resided in the facility. [Refer to Tag C0296 10A NCAC 13G. 0906(a) Other Resident Services (TYPE B VIOLATION)].</p> <p>8 .Based on record reviews and interviews, the facility failed to assure medications were</p>	C 912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 912	Continued From page 136  administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 residents sampled (#1, #2, #3) including errors with an oral antidiabetic (#1, #2), an antibiotic (#1, #2), an antipsychotic (#1, #2), an antiulcer (#2), a pain medication (#2), an anti-anxiety medication (#1), a probiotic, and gastroesophageal reflux medication (#3). [Refer to Tag C330 10A NCAC 13G. .1004(a) Medication Administration (TYPE A1 VIOLATION)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights  Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.  This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were not neglected as it relates to housekeeping and furnishings, fire safety and disaster plan, building service equipment, personal care and supervision, health care, and medication administration. The findings are:  1. Based on observations and interviews, the facility failed to assure the walls were clean and in good repair in 3 of 3 resident bedrooms, the common resident bathroom, living room and hallway, and the ceiling was in clean and in good repair in the living room and bathroom, and the floors were clean and in good repair in the 2 of 3 resident bedrooms, the common bathroom, and the kitchen. [Refer to Tag C0074 10A NCAC 13G. 0315(a)(1) Housekeeping and Furnishings (TYPE B VIOLATION)].	C 914		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 914	<p>Continued From page 137</p> <p>2. Based on observations and interviews, the facility failed to assure the facility bathroom, kitchen, living room, 3 of 3 resident bedrooms, and outside grounds were kept clean, uncluttered, and free of hazards. [Refer to Tag C0078 10A NCAC 13G. 0315(a)(5) Housekeeping and Furnishings (TYPE B VIOLATION)].</p> <p>3. Based on interviews, record reviews, and observations, the facility failed to replace the batteries in one smoke detector in order to maintain a working fire alarm system. [Refer to Tag C0097 10A NCAC 13G. 0316(b) Fire Safety and Disaster Plan (TYPE B VIOLATION)].</p> <p>4. Based on observations, record reviews, and interviews, the facility failed to assure fire drills were completed quarterly in 2015 and 2016. [Refer to Tag C0100 10A NCAC 13G. 0316(e) Fire Safety and Disaster Plan (TYPE B VIOLATION)].</p> <p>5. Based on observation and interview, the facility failed to assure all plumbing equipment in the facility was maintained in a safe and operating condition as related to the water pump providing adequate water for residents' showers. [Refer to Tag C0102 10A NCAC 13G. 0317(a) Building Service Equipment (TYPE B VIOLATION)].</p> <p>6. Based on record reviews and interviews, the facility failed to assure that 4 of 6 residents sampled (#1, #2, #4, #5) went to appointments with their medical and mental health providers resulting in Resident #1 developing infection from a surgical procedure; and, failed to notify the health care provider or seek emergency treatment for 3 of 6 residents sampled (#1, #2,</p>	C 914		

Division of Health Service Regulation

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C 914	Continued From page 138  #3) who had requested physician visits for pain (#1) and allegations of being raped (#2) and who had refused blood pressure medication (#3). [Refer to Tag C0246 10A NCAC 13G. 0902(b) Health Care (TYPE A1 VIOLATION)].  7. Based on record reviews and interviews, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 3 of 5 residents sampled (#1, #2, #3) including errors with oral antidiabetic medications (#1, #2), antibiotics (#1, #2), antipsychotics (#1, #2), an antiulcer (#2), a pain medication (#1), an anti-anxiety medication (#1), a probiotic, and gastroesophageal reflux medication (#3) resulting in residents going without medications for several days. [Refer to Tag C330 10A NCAC 13G. .1004(a) Medication Administration (TYPE A1 VIOLATION)].	C 914		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements  G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements  (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care	C 934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 934	<p>Continued From page 139</p> <p>home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 3 of 3 staff sampled (A, B, and C) completed the state mandated infection control training annually.</p> <p>The findings are:</p> <p>1. Review of Staff A's personnel record revealed: -Staff A was hired 06/17/14 as a Medication Aide (MA) -There was no documentation of Staff A completing infection control training.</p> <p>Staff A was not available for interview.</p> <p>Interview with the Administrator on 07/14/16 at 1:25pm revealed Staff A was out on leave at the time of the survey.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <p>2. Review of Staff B's personnel record revealed: -Staff B was hired 01/17/14 as "Direct Care Staff." -There was documentation of Staff B completing infection control training on 11/21/14. -There was no additional documentation of Staff B completing infection control training.</p> <p>Interview with Staff B on 07/14/16 at 8:40am revealed Staff B performed cooking, cleaning, transportation, and MA duties in the facility.</p> <p>Interview with Staff B on 07/28/16 at 7:00am</p>	C 934		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C 934	<p>Continued From page 140</p> <p>revealed Staff B thought she had infection control training but was not sure of the date.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <p>3. Review of Staff C's personnel record revealed: -Staff C was hired 09/11/13 as the Supervisor in Charge (SIC). -There was no other documentation of Staff C completing infection control training.</p> <p>Interview with Staff C on 07/14/16 at 1:45pm revealed: -Staff C was the SIC and completed cooking, transportation, and MA duties in the facility. -Staff C recalled having the annual infection control training at another family care home that she worked in but she was not sure of the date of the training.</p> <p>Refer to the interview with the Administrator on 07/14/16 at 1:59pm.</p> <p>Interview with the Administrator on 07/14/16 at 1:59pm revealed: -The Administrator was responsible for all staff training, credentials, and records. -The Administrator thought all staff had completed the infection control training. -The Administrator was not aware infection control training was required annually. -The Administrator thought printing the infection control training and having staff read the training materials met the training criteria. -The Administrator would fax documentation of staff's annual infection control training to the surveyor, if she found it.</p>	C 934		

Division of Health Service Regulation

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C935	Continued From page 141	C935		
C935	<p>G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p> <p>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ul style="list-style-type: none"> <li>a. The key principles of medication administration.</li> <li>b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.</li> </ul> <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <ul style="list-style-type: none"> <li>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: <ul style="list-style-type: none"> <li>1. The key principles of medication administration.</li> <li>2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding</li> </ul> </li> </ul>	C935		

Division of Health Service Regulation

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C935	<p>Continued From page 142</p> <p>exists.</p> <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 Medication Aides (MAs) sampled (Staff A) hired after 10/01/13 completed the mandated 5 hour, 10, hour, or 15 hour Medication Aide training.</p> <p>The findings are:</p> <p>Review of Staff A's personnel record revealed: -Staff A was hired 06/17/14 as a Medication Aide (MA) -There was documentation that Staff A successfully passed the MA Test on 08/12/13. -There was validation of medication clinical skills dated 06/23/14. -There was no documentation of Staff A completing the 5, 10, or 15 hour MA training.</p> <p>Review of the May, June and July 2016 Medication Administration Records (MARs) revealed: - Staff A initialed the May 2016 MARs as documentation of administering medications to Resident #3 and Resident #4 in May 2016. -Staff A initialed the June 2016 MARs as documentation of administering medications to Resident #1, Resident #2, and Resident #4 in June 2016. - Staff A initialed the July 2016 MARs as documentation of administering medications to Resident #1.</p> <p>Staff A was not available for interview.</p>	C935		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL071014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/28/2016</b>
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C935	<p>Continued From page 143</p> <p>Interview with the Administrator on 07/14/16 at 1:25pm revealed Staff A was out on leave at the time of the survey.</p> <p>Interview with the Administrator on 07/14/16 at 1:59pm revealed: -The Administrator was responsible for all staff training, credentials, and records. -The Administrator thought Staff A had completed all of the required MA training.</p>	C935		