STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL009028	A. BUILDING: _____ B. WING _____	R-C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE FAMILY CARE HOME	583 SASAFRAS ROAD BLADENBORO, NC 28320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on June 4th through June 6th, 2019.	{C 000}		
{C 069}	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 exit doors had sounding devices that were activated and sounded when the exit doors were opened to alert staff for 1 of 4 residents sampled (#2) who was constantly disoriented. The findings are: Observations of the facility at various times tour on 06/04/19 from 9:50am to 11:50am revealed:	{C 069}		

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{C 069}	Continued From page 1 -When the main front entrance door was opened to the facility, the alarm sounding device did not alarm. -When the side kitchen door was opened to the facility, the alarm sounding device did not alarm. -The front entrance door and the side kitchen door were equipped with an alarm sounding device. -The back double sliding glass doors were equipped with an alarm sounding device but were not able to be opened. Confidential interviews with two residents revealed: -They had not heard the door alarms sound in "about a week". -The supervisor-in-charge (SIC) sometimes turned on the door alarm on the front door. -The residents only used the front door to go in and out of the facility. Observation of the facility on 06/04/19 at 11:19am revealed the SIC turned on the door alarms to the main front entrance and the side kitchen door. Interview with a SIC on 06/04/19 at 11:20am revealed: -She "forgot to turn on the door alarms back on" after the residents went out to smoke earlier this morning. -The door alarms were always supposed to be on in the facility. Observation of the facility 06/05/19 from 9:35am to 10:45am revealed the sounding devices did not alarm when main front entrance door or the side kitchen door were opened. Observation of the SIC on 06/05/19 at 10:45am revealed she had a key ring with four remotes	{C 069}		

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{C 069}	Continued From page 2 that she used to activate the alarms on the main front entrance door and the side kitchen door. Interview with the Administrator on 06/05/19 at 12:56pm revealed: -All the exit doors were equipped with door alarms which should alarm each time the doors were opened. -The Administrator and the SIC were responsible to make sure the alarms were activated on all the doors. -She checked at least once a week to ensure the SIC activated the door alarms in the facility. -If any of the door alarms were off, then the SIC "just forgot to turn the door alarms back on". -She knew the door alarms were always supposed to be on in the facility because there was one resident who was confused at times. Observation of the facility on 06/06/19 at 12:45am revealed the main front entrance door was unlocked, and the sounding device did not alarm when the front entrance door was opened by the survey team. Interview with the same SIC on 06/06/19 at 1:16pm revealed: -She was the SIC on duty at 12:45am on 06/06/19. -She never locked the main front entrance door at night. -She saw a car's light in the facility's driveway during the early morning of 06/06/19. -She turned off the door alarm on the main front entrance door during the early morning of 06/06/19 so her family member could get inside the facility after she saw a car's light in the facility's driveway. -She sometimes forgot to turn on the door alarms for exit doors, but she remembered she turned	{C 069}		

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{C 069}	Continued From page 3 the sounding device off on the front door on the morning of 06/06/19 and that was why it did not sound. Interview with the Administrator on 06/06/19 at 2:37pm revealed: -The SIC told her she turned off the door alarm on the main front entrance on the previous night, so the other family member could get inside the facility when the SIC saw car lights in the yard at 12:45am. -She did not understand why the SIC turned off the door alarm on the front door if the front door was already unlocked. -She did not know why the front door was unlocked on the morning of 06/06/19. -The front doors were supposed to be locked at 10pm in the facility and the door alarms were always supposed to be on. Review of Resident #2's current FL-2 dated 05/17/19 revealed: -Diagnoses included hypertension, Type II - diabetes mellitus, hyperlipidemia, gastroesophageal reflux disease, schizophrenia, bursitis and osteoarthritis. -There was no documented assessment of the resident's orientation level. Review of Resident #2's previous FL-2 dated 11/20/18 revealed: -Diagnoses included hypertension, type II diabetes, and schizophrenia. -There was documentation the resident was ambulatory and constantly disoriented. Review of Resident #2's care plan dated 01/31/19 revealed Resident #1 was sometimes disoriented, forgetful, and needed reminders.	{C 069}		

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{C 069}	Continued From page 4 Review of Resident #2's Resident Register dated 11/30/18 revealed she was forgetful and required reminders. Review of a letter of appointment of a guardian of the person dated 04/23/08 revealed Resident #2 was adjudicated incompetent by the court and appointed a guardian. Observation Resident #2 on 06/04/19 at 10:40am revealed Resident #2 was alert and oriented to person and place only. Observation of Resident #2 on 06/04/19 from 10:43am to 10:59am was sitting on the front porch of the facility smoking a cigarette and dressed appropriately. Telephone interview with Resident #2's guardian on 06/06/19 at 8:49am revealed: -Resident #2 was forgetful and confused at times. -Resident #2 needed reminders and supervision because of her intermittent confusion to ensure her safety and well-being. Third interview with the SIC on 06/06/19 at 1:16pm revealed: -Resident #2 was intermittently confused at times and said things that were not true. -Resident #2 had previously left the facility "to walk down the road or go the creek" but Resident #2 has not done that since she was first admitted to the facility sometime last fall. -The creek was not quite a half a mile down the road from the facility. -Resident #2 was forgetful at times and needed reminders from staff to ensure her safety. -The staff was responsible to ensure the door alarms were activated on all the exit doors, but she sometimes forgot to turn the door alarms	{C 069}		

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{C 069}	Continued From page 5	{C 069}		

back on.
-If the door alarms were not activated, it was possible for Resident #2 to leave the facility without staff's knowledge.

Second interview with the Administrator on 06/06/19 at 2:37pm revealed:
-Resident #2 was occasionally confused, but staff assisted the resident mainly with her grooming and personal hygiene needs.
-Resident #2 was forgetful.
-She knew the door alarms were always supposed to activated on all the exit doors.
-The SIC was supposed to make sure this was done, and she had performed checks at least weekly to ensure the SIC was always keeping the facility's door alarms on.
-She had never checked the facility's door alarms in the middle of the night to make sure they were on.
-The door alarms were supposed to alert the staff if a resident left the facility without letting the staff know.

Telephone interview with the primary care provider for Resident #2 on 06/06/19 at 6:35pm revealed:
-He had acquired the primary care of Resident #2 from another provider around 03/27/19.
-He did not know Resident #2 very well because he had only seen her one time in his office and she was accompanied by the Administrator.
-Resident #2 presented as "alert" during the fifteen minute-time window he saw her during her only office visit.
-The Administrator did not share with him that Resident #2 had any problems with her orientation status or if Resident #2 had any problems with wandering.
-He was still in the "getting to know you phase" in

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{C 069}	Continued From page 6 dealing with his patients. _____ The facility failed to assure 2 of 4 exit doors had activated sounding devices when the doors were opened and one of the residents had been adjudicated incompetent (#2). This failure was detrimental to the safety and welfare of Resident #2 and constitutes an unabated Type B Violation. _____ The facility provided a plan of protection on June 6, 2019 in accordance with G.S. 131D-34 for this violation.	{C 069}		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 4 residents sampled (#1, #3) with a documented histories of mental illness (#1, #3) and intellectual disability (#3) who were allowed to go to a creek and busy intersection unsupervised and the facility failed to provide supervision to 4 of 4 residents sampled (#1, #2, #3, #4) for at least thirty minutes during third shift on 06/06/19 for residents with a documented histories of mental illness (#1, #2, #3, #4) and intellectual disability (#3) as evidenced by staff reporting being unavailable to supervise the residents for at least 30 minutes while taking a shower behind four	C 243		

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C 243	Continued From page 7 locked interior facility doors. The findings are: 1. Confidential interview with a resident revealed: -Resident #1 and Resident #3 walked to the creek and the stop sign near the facility sometimes. -Staff did not go with Resident #1 or Resident #3 when they went to the creek or the stop sign. -Residents signed themselves out sometimes and left the facility. -Resident #1 and Resident #3 sometimes left the facility at night and went to the creek and the stop sign, but the staff did not know it. Observation of the creek area located near the facility on 06/05/19 at 11:35am revealed: -The creek area was located approximately 1/3 of a mile from the facility on the right side of the highway. -The mouth of creek was approximately 18 feet wide at its widest point and approximately 14 feet at its narrowest visible point. -There was at least an eight-foot drop between the side of the highway and the creek bank. -The creek area contained brown water of unknown depth and the bottom of the creek bed was not visible. -The creek bank was covered with grass, reeds, and rocks. -The creek wound back into the wooded area adjacent to the highway. Observation of the stop sign located near the facility on 06/05/19 at 11:45am revealed the stop sign was located at the end of the two-lane highway which was a little over a ½ of mile from the facility and merged into the curve of a T-intersection of a two-lane state highway.	C 243		

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C 243	Continued From page 8 Interview with a Supervisor-in-Charge (SIC) on 06/06/19 at 1:16pm revealed: -Resident #1 and Resident #3 sometimes walked to the creek and the stop sign near the facility. -Staff did not go with the Resident #1 or Resident #3 when they went on these walks. -Resident #1 and Resident #3 usually went together whenever they went to the creek or the stop sign. -There had never been problem with either resident leaving the facility and not returning when they took their walks. -She did not think there was any problem with Resident #1 or Resident #3 leaving the facility unsupervised even though both residents had histories of mental illness and intellectual disabilities. -She knew both Resident #1 and Resident #3 had been declared legally incompetent and each had a court appointed guardian. -Both residents usually signed out when they left the facility but sometimes they did forget to sign. -She did not know anything about Resident #1 or Resident #3 leaving the facility at night to go to the creek or to the stop sign. Interview with the Administrator on 06/05/19 at 10:16am revealed: -Resident #1 and Resident #3 sometimes went to the creek that "was a little way down the road" from the facility. - "The creek was like a small swamp-like area, but it was probably dried up now because there had not been much rain." -She used to swim in the creek when she "was a kid" and she wondered why she "had not been bitten by a snake" when she swam there. -She was not worried about the residents when they walked to the creek and no staff went with	C 243		

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C 243	Continued From page 9	C 243		

the residents when the residents went to the creek areas.
-She was not sure how far the creek or the stop sign was from the facility.
-Resident #1 and Resident #3 walked to the stop sign because "it was just something to do".
-Neither resident was ever gone long, and they always came back to the facility.
-She was not sure when was the last time either resident had been to the creek or the stop sign.
-She did not think Resident #1 or Resident #3 were in any danger when they went to the creek or the stop sign unsupervised.

Telephone interview with the primary care provider for Resident #1 and Resident #3 on 06/06/19 at 6:35pm revealed:
-He had acquired the primary care of Resident #1 and Resident #3 from another provider.
-He did not know Resident #1 or Resident #3 very well because he had only seen each resident one time in his office and each resident was accompanied with the Administrator.
-Resident #1 and Resident #3 presented as "alert" during the fifteen minute-time window he saw them during their only office visit.
-The Administrator did not share with him that either resident had been legally declared incompetent or if either resident had any cognitive issues.
-He did not know Resident #1 or Resident #3 were taking walks to the creek or the stop signs without staff supervision.
-It was his expectations for the facility staff to accompany Resident #1 and Resident #3 for supervision when the residents left the facility premises.
-He had not told the staff at the facility because the facility had not shared with him that Resident #1 and Resident #3 were leaving the facility

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C 243	Continued From page 10 unsupervised for walks to the creek and stop sign. a. Review of Resident #1's FI-2 dated 05/30/19 revealed diagnoses included schizophrenia and there was no documented assessment of the resident's orientation. Review of Resident #1's care plan dated 02/13/19 revealed Resident #1's was oriented, and he was forgetful and needed reminders. Review of a letter of appointment of a guardian dated 01/24/17 revealed Resident #1 was adjudicated incompetent by the court and appointed a guardian of person. Review of the facility's sign-out register revealed: -Resident #1 signed out to go to the "creek" from 4:05pm to 5:05pm on 03/18/19. -Resident #1 signed out to go to the "creek" from 2:10pm to 2:30pm on 03/30/19. -Resident #1 signed out to go to the "stop sign" from 9:45am to 10:50am on 04/03/19. Interview with Resident #1 on 06/04/19 at 11:28am revealed: -He had some mental health issues, but he was "okay" if he took his medications and kept his appointments with his therapist. -He "liked living at the facility because it was quiet", and it kept him "out of trouble". -He sometimes walked to "a creek area and the stop sign" that was located by the facility to have something to do. -He could not specify when the last time that he walked to the creek or the stop sign. -Staff did not go with him when he walked to the creek or the stop sign.	C 243		

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C 243	Continued From page 11 Attempted interview with Resident #1's guardian on 06/06/19 at 10:30am was unsuccessful. b. Review of Resident #3's current FL-2 dated 05/15/19 revealed: -Diagnoses included mild intellectual disability, dysthymic disorder, bipolar disorder and depressed mild or moderate. -There was no documented assessment of the resident's orientation. Review of Resident #3's care plan dated 02/13/19 revealed Resident #1 was oriented, forgetful, and needed reminders. Review of a letter of appointment of a guardian dated 02/11/13 revealed Resident #3 was adjudicated incompetent by the court and appointed a guardian. Review of the facility's sign-out register revealed: -Resident #3 signed out to go to the "creek" from 4:05pm to 5:05pm on 03/18/19. -Resident #3 signed out to go to the "creek" from 2:10pm to 2:30pm on 03/30/19. Telephone interview with Resident #3's guardian on 06/06/19 at 8:49am revealed: -She last saw Resident #3 at the facility in sometime in May 2019. -Resident #3 was intellectually disabled and required supervision to ensure her safety. -She did not know Resident #3 took walks in the community without supervision of the facility's staff. -It was her expectation for facility staff to provide supervision of the Resident #3 during her community walks. Attempted interview with Resident #3 on 06/05/19	C 243		

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C 243	Continued From page 12 at 10:00am was unsuccessful. 2. Confidential interview with a resident revealed: -Staff C and Staff D had left the residents "many times at night and would not tell" the residents when the staff left the facility. -The resident would fell asleep between 12:00 midnight to 1:00am and there would be no staff in the facility. -Staff C and Staff D would be back in the facility when the resident woke up in the morning (no time specified). Interview with the Administrator on 06/04/19 at 11:49am revealed "staff were always in the building" and the residents were not left alone or unsupervised. Observation of the facility on 06/06/19 from 12:45am to 1:30am revealed: -The survey team arrived at the facility at 12:45am. -The light from facility's office was visible from the outside of the facility. -A member of the survey team approached the front door of the facility and the second member of the survey team approached the side kitchen door of the facility. -The porch light from the house next door to the facility came on and then went off. -Staff D emerged from the house next door in the dark; he walked up the pathway to the front steps of the facility; and met the survey team on the front porch of the facility. -There was no connecting passageway between the facility and the house next door. -Staff D attempted to call Staff C on his cell phone who was supposed to be inside the facility. -Staff D instructed the survey team member to go inside the facility while he was attempting to	C 243		

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reach Staff C by phone.
-The first survey team member entered through the main entrance door of the facility at approximately 12:50am.
-The main entrance door was unlocked and there was no sounding door alarm upon entrance of the facility.
-The survey team member went down the foyer into the living room area of the facility that was lit only by the light of the television and no residents were present in the living room.
-The living room opened into the main hallway where the bedrooms of the four residents were located on the right side of the main entrance.
-All the residents' bedroom doors were closed, and the main hallway was dark.
-The kitchen door located on the left side of the living room area was closed.
-When the first survey team member attempted to open the kitchen door, she found she was unable to turn the door knob of the kitchen door because it was locked and there was also a deadbolt lock in place near the middle of the kitchen door.
-The first survey team member knocked repeatedly on the locked kitchen door, attempted repeatedly to turn the locked door knob of kitchen door, and called out for Staff C several times; but Staff C did not answer, and the kitchen door remained locked.
-Staff D came down the ramp on front left side of the facility to the carport by the side kitchen door to let the second survey team member in the facility.
-Staff D was observed attempting to make a call on his cell by the second survey team member.
-The second survey team member went up the ramp along the front of the facility and through the front main entrance door.
-The front main entrance door was unlocked and

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C 243	Continued From page 14 there was no sounding door alarm with the second survey team member entered the facility. -The first survey member met the second survey team member at the front door entrance. -Both survey team members went back to the living room area to the locked kitchen door. -The survey team began to knock on the locked kitchen door again and called out to Staff C and there was still no response from Staff C. -Staff D was outside of the facility. -The survey team members went to check on the residents who were located down the main hallway of the facility. -Staff D came in the facility through the main entrance and there was no sounding door alarm when he entered the facility. -The survey team was at the end of the main hallway when Staff D entered the living room area. -The survey team walked back up the facility's main hallway towards Staff D who was standing at the top of the main hallway at the entrance of the living room area. Interview with Staff D on 06/06/19 at 1:12am revealed: -Staff C was the Supervisor-in-Charge (SIC) currently working. -He was next door at his home and Staff C called him about seeing car lights in the facility's driveway. -He came over to the facility and saw the survey team. -He tried to reach Staff C on the cell phone several times since he saw the survey team, but she did not answer. -He thought Staff C may have been in the shower in the staff quarters and she could not hear the phone.	C 243		

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C 243	Continued From page 15 Observation of the facility on 06/06/19 at 1:19am revealed: -The survey team went back to the locked kitchen door, knocked and called for Staff C again. -Staff C still did not respond to the survey team repeated knocks or calls. -Staff D walked over to the locked kitchen door, knocked, and called out to Staff C. -The survey team heard the locks on the kitchen door being unlocked and Staff C opened the kitchen door. -Staff C appeared startled and wide-eyed when she opened the kitchen door. -The light was on in the kitchen and Staff C stood in the kitchen doorway. -Staff C was wearing a t-shirt and shorts and her hair and skin were dry. -The kitchen door entrance by the living room was only access to the staff quarters in the facility and located at the opposite end of the facility away from resident quarters. -Access to the staff quarters was the kitchen area and access through a hall door on the left side of kitchen and staff quarters were located approximately six feet down a small hallway area on the right. -The kitchen hallway door and staff quarters door were both equip with door knob locks. Interview with the Staff C on 06/06/19 at 1:19am revealed: -She was the SIC currently working at the facility. -She did not hear the survey team members knocking on the kitchen door. -She may have been in the staff quarters and she could not hear the knocking on the kitchen door, the turning of door knob, or her name being called through the closed staff quarter door with the closed kitchen door. -She could not explain why she did not answer	C 243		

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her phone when Staff D attempted to call her.
-She had called Staff D earlier when she saw the car lights in the driveway and she did not know who was outside the facility and then she went and took a shower.

Observation of the facility's residents on 06/06/19 from 1:21am to 1:27am revealed:
-Staff C remained standing in the kitchen doorway and Staff D stood in the living room area while the survey team checked the residents.
-No lighting was visible from any of the residents' rooms as the survey team walked down the facility's main hallway.
-Resident #4 was found asleep in his bed in his room located on the right side at the end of the facility's main hallway.
-Resident #1 was not found in the room that he shared with Resident #4.
-Resident #2 was asleep in her bed with a night light on in the second bedroom on the right side of the main hallway.
-The survey team was unable to fully access Resident #2's room because her room door was latched with a hook and eye lock.
-The survey team attempted to access Resident #3's room which was the first bedroom on the right but found the room door was locked.
-Resident #3 responded verbally to the survey team but would not open the bedroom door for the survey team.
-Resident #3 denied that Resident #1 was in the room with her.
-Staff D went to Resident #3's door, knocked on the door, called Resident #3's name, and attempted to open the door, but the door was locked.
-Staff D asked Resident #3 (through the locked door) if Resident #1 was in the room with her.
-Resident #3 denied that Resident #1 was in her

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C 243	Continued From page 17 room. -Staff D knocked on Resident #3's door again and called Resident #1's name two times before Resident #1 answered and acknowledged that he was in the room with Resident #3. -Resident #3's room door did not open. Interview with Staff D on 06/06/19 at 1:27am revealed: -He did not know why the front door was unlocked and he did not notice if the alarm sounded on the front door when he entered. -He did not know why the kitchen door had been locked. -He "was not worried" about where Resident #1 was because he knew Resident #1 was probably in Resident #3's room. -Resident #1 stayed in Resident #3's room sometimes at night. -He did not specify how often Resident #1 stayed in Resident #3's room at night. -He did not know Resident #3 had a lock on her door or Resident #2 had a hook lock on her door. -None of the residents were supposed to have locks on their bedroom doors. -He did not check the residents once the residents went to bed. Interview with Staff C on 06/06/19 at 1:27am revealed: -She believed Resident #1 was in Resident #3's room. -Resident #1 often stayed in Resident #3's room. -If she could not find Resident #1 in his room then she knew to look for him in Resident #3's room. -She did not know Resident #3's room door had a lock on it or how long the lock had been on the door. -She had never noticed if Resident #3's room door was locked before.	C 243		

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C 243	Continued From page 18 -She did not know about the hook lock on Resident #2's door or how long the hook lock had been there. -She did not check on the residents once the residents went to bed unless they rang their call bells. Confidential interview with a second resident revealed: -Staff C and Staff D lived in the house next door to the facility. -Staff C and Staff D stayed in the facility at night about "half the time". -"Some nights they (Staff C and Staff D) stayed" at the facility and "some nights they stayed at their house next door. -Staff slept in the staff quarters when they stayed at the facility at night. -Staff C and Staff D both worked as SICs at the facility. Second interview with Staff C on 06/06/19 at 1:16pm revealed: -She was the SIC on duty at 12:45am on 06/06/19. -She never locked the main front entrance door at night because she thought it was against state rules. -She did not think the residents were in danger by leaving the front door of the facility unlocked at night. -She was inside the staff quarters when she saw car lights in the facility's driveway during the early morning of 06/06/19. -She did not know who was in the driveway, so she called Staff D to come to the facility. -She remotely turned off the sounding device on the main front entrance door from the staff quarters, so Staff D could get inside the facility. -She sometimes forgot to turn on the sounding	C 243		

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devices for exit doors, but she remembered she turned the sounding device off on the front door on the morning of 06/06/19 and that was why it did not sound.
-She came out the staff quarters and locked both locks on the kitchen door and then locked herself inside the staff quarters because she was scared after she called Staff D.
-Then she locked herself inside the staff bathroom and took a shower.
-She always locked the kitchen door by the living room, the staff quarters' door, and the staff bathroom door when she took a shower in the facility.
-The exhaust fan in the staff bathroom was loud so it was possible if the exhaust fan was on in the staff bathroom and the kitchen, staff quarter, and staff bathroom doors were all closed, that she may have not heard the survey team knocking or calling out for her.
-She did not verbalize any other attempts to contact Staff D after her initial call about the car lights in the yard on the morning of 06/06/19.
-She did not remember saying she "could not hear the knocking on the kitchen door, the turning of door knob, or her name being called" by the survey team earlier on the morning of 06/06/19.
-She did not know what she was doing that prevented her from hearing the knocking on the kitchen door or when the survey team called her name.
-The kitchen door entrance by the living room was locked at night to keep the residents from "rambling in the kitchen" and eating up all the food (time not specified when kitchen door was locked at night).
-The only inside access to the staff quarters was through the facility kitchen that was located to the right of the facility's office.
-There were call bells in the residents' rooms, but

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no call bells in the two residents' bathrooms or the living room.
-She could hear the residents when they rang their call bells in the staff quarters, but she would not be able to hear the call bells if she was in the shower or if a resident needed help in the living room or bathroom while the kitchen door was locked.
-She was the only staff present in the facility when she took her showers when she worked at the facility.

Interview with the Administrator on 06/06/19 at 2:37pm revealed:
-She did not know why there was delayed response from Staff C when the survey team or Staff D tried to contact Staff C in the early morning of 06/06/19.
-Staff C did not tell her that she was taking a shower while working on 06/06/19.
-Staff were not supposed to take showers while they were working at the facility.
-Staff were expected to be available for the residents and staff could not be available if the staff was in the shower.
-The facility did have a call bell system in the residents' rooms, but the locked kitchen door and locked staff quarter doors may make it hard for staff to hear residents call for assistance if they are not near a call bell.
-She did not know there was a hook lock on Resident #1's bedroom door or a door knob lock on Resident #2's bedroom door.
-She did not understand how staff had been checking on those residents if those residents' room doors were locked at night.
-Resident #1 and Resident #3 "spent a lot of time together".
-She expected Resident #1 to sleep in his own room and Resident #3 to sleep in her own room

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C 243	Continued From page 21 at night. -Resident #1 and Resident #3 did not sleep in the same room when she worked the facility at night (no time specified). a. Review of Resident #1's FI-2 dated 05/30/19 revealed diagnoses included schizophrenia and there was no documented assessment of the resident's orientation level. Review of Resident #1's care plan dated 02/13/19 revealed Resident #1's was oriented, and he was forgetful and needed reminders. Review of a letter of appointment of a guardian dated 01/24/17 revealed Resident #1 was adjudicated incompetent by the court and appointed a guardian of person. Attempted interview with Resident #1's guardian on 06/06/19 at 10:30am was unsuccessful. b. Review of Resident #2's current FL-2 dated 05/17/19 revealed: -Diagnoses included hypertension, Type II - diabetes mellitus, hyperlipidemia, gastroesophageal reflux disease, schizophrenia, bursitis and osteoarthritis. -There was no documented assessment of the resident's orientation level. Review of Resident #2's previous FL-2 dated 01/31/19 revealed: -Diagnoses included schizophrenia, hypertension and diabetes mellitus type II. -There was documentation the resident was constantly disoriented and was ambulatory. Review of Resident #2's care plan dated 01/31/19 revealed Resident #1 was sometimes disoriented,	C 243		

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C 243	Continued From page 22 forgetful, and needed reminders. Review of a letter of appointment of a guardian of the person dated 04/23/08 revealed Resident #2 was adjudicated incompetent by the court and appointed a guardian of person. Telephone interview with Resident #2's guardian on 06/06/19 at 8:49am revealed: -Resident #2 had a history of mental illness. -She was forgetful and confused at times and she required supervision to ensure her safety. c. Review of Resident #3's current FL-2 dated 05/15/19 revealed: -Diagnoses included mild intellectual disability, dysthymic disorder, bipolar disorder and depressed mild or moderate. -There was no documented assessment of the resident's orientation level. Review of Resident #3's care plan dated 02/13/19 revealed Resident #1 was oriented, forgetful, and needed reminders. Review of a letter of appointment of a guardian dated 02/11/13 revealed Resident #3 was adjudicated incompetent by the court and appointed a guardian. Telephone interview with Resident #3's guardian on 06/06/19 at 8:49am revealed the resident was intellectually disabled and required supervision to ensure her safety. d. Review of Resident #4's current FL-2 dated 02/13/19 revealed: -Diagnoses included moderate manic bipolar disorder, suicidal thoughts, and was injurious to self.	C 243		

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C 243	Continued From page 23 -There was no documented assessment of the resident's orientation level. Review of Resident #4's previous hospital generated FL-2 dated 01/07/19 revealed: -Diagnoses included aggressive behavior and moderate manic bipolar disorder. -There was no documented assessment of the resident's orientation level. Review of Resident #4's care plan dated 02/13/19 revealed Resident #1 was oriented, forgetful, and needed reminders. Review of Resident #4's Resident Register dated 10/09/17 revealed Resident #4 was his own responsible person. _____ The facility failed assure 2 of 4 residents who were deemed incompetent and had mental illness (#1, #3), and had an intellectual disability (#3) were provided staff supervision when they left the facility to go to a nearby body of water and busy highway area and failed to provide supervision for 4 of 4 residents sampled residents (#1, #2, #3 & #4) for at least 30 minutes when staff was not accessible to the residents as evidenced by being locked behind at least 4 interior facility doors while taking a shower. The facility's failure was detrimental to the health and safety of the residents in the event of an emergency and constitutes a Type B Violation. _____ The facility provided a plan of protection on June 6, 2019 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 25, 2019.	C 243		

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C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure referral and follow up for acute and routine health care needs for 1 of 4 sampled residents (#2) with a diagnosis of glaucoma. The findings are: Review of Resident #2's current FL-2 dated 05/17/19 revealed diagnoses included hypertension, diabetes mellitus type two, hyperlipidemia, gastroesophageal reflux disease, schizophrenia, bursitis, and osteoarthritis. Interview with Resident #2 on 06/04/19 at 10:39am revealed: -She needed help to get some eye glasses. -She said she could not see. Review of Resident #2's eye doctor's progress note dated 04/02/19 revealed: -Resident #2 was treated for glaucoma. -There was a prescription for new eye glasses that needed to be filled. -Resident #2 was to receive eye laser treatment for glaucoma.	C 249		

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C 249	Continued From page 25 Review of Resident #2's eye doctor's progress note dated 04/10/19 revealed Resident #2 received eye laser treatment for glaucoma. Review of Resident #2's eye doctor's progress note dated 04/23/19 revealed: -Resident #2 received eye laser treatment for glaucoma. -Resident was scheduled to return on 06/24/19 at 1:30pm for follow up appointment. Observation of Resident #2 on 06/05/19 at 3:06pm revealed resident was wearing mirrored sunglasses. Interview with Resident #2 on 06/05/19 at 3:06pm revealed: -The Administrator took her to the eye doctor last month. -The eye doctor told her she had glaucoma and she needed eye laser treatment. -The eye doctor wrote a prescription for eyeglasses for her during her first visit (time not specified). -She gave the eyeglasses prescription to the Administrator after her appointment. -The Administrator never took her to get her new eyeglasses. -She received the eye laser treatment for both her eyes last month. -She was having problems with headaches, eye pain, and some blurred vision for least a month. -She had brought a pair of shades on 06/04/19 during a facility outing. -She felt the sunglasses helped her to see better by keeping light from getting into her eyes. -She needed her eyeglasses and she did not know why she had not gotten them yet. -The Administrator had her eyeglasses	C 249		

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prescription long enough for her to have her new eyeglasses.
-She was afraid that her eyeglasses prescription would expire before she had the opportunity to get them.

Interview with nurse for Resident #2's eye doctor on 06/04/19 at 4:57pm revealed:
-Resident #2 was seen on 04/02/19.
-The eye doctor prescribed eye drops for glaucoma and wrote a prescription for eyeglasses on 04/02/19.
-Resident #2 received eye laser treatment procedure for glaucoma on 04/10/19 and 04/23/19.

Interview with Supervisor-in-Charge (SIC) on 06/06/19 at 1:16pm revealed:
-Resident #2 saw the eye doctor a few weeks ago, but she was not sure of the exact date.
-Resident #2 was given a prescription for eyeglasses a month or so ago and she had filed it separately from Resident #2's record.
-The Administrator gave the SIC the prescription for Resident #2's eyeglasses and she filed the prescription away.
-Resident #2 wore sunglasses and she asked the resident if she could "see in them".
-Resident #2 purchased a pair of sunglasses on 06/04/19 while out on a facility outing.
-She did not know Resident #2 had experienced any headaches, blurred vision and eye pain or complained about needing her eyeglasses.

Review of a prescription for Resident #2 revealed a prescription for eyeglasses written on 04/23/19.

Interview with Resident #2's legal guardian on 06/06/19 at 8:50am revealed:
-She saw Resident #2 last on 05/22/19 when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL009028	A. BUILDING: _____ B. WING _____	R-C 06/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE FAMILY CARE HOME	583 SASAFRAS ROAD BLADENBORO, NC 28320

(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 249	Continued From page 27	C 249		

took her for a follow up dentist appointment.
-She called regularly and spoke with SIC and Administrator to get updated on Resident #2.
-She visited Resident #2 quarterly normally, or sooner if needed.
-The Administrator attended doctor appointments with Resident #2.
-She knew only of her dentist appointments.
-The SIC told her on 05/22/19 on her last visit there with Resident #2 that she would schedule an eye appointment for Resident #2.
-She did not know that Resident #2 had been seen by the eye doctor.
-She had no record that the SIC or any other facility staff tried to contact her regarding any eye appointment for Resident #2.
-She did not know eyeglasses or eye laser treatment had been prescribed for Resident #2.
-She did not know Resident #2 had been experiencing headaches, blurred vision, and eye pain because she did not have her eyeglasses.
-Her expectations were for facility staff to coordinate, follow up on any appointments or needs/services for Resident #2 in a timely manner and to keep her informed.

Interview with the Administrator A on 06/06/19 at 2:10pm revealed:
-He took her to the eye doctor appointment roughly a month ago.
-He was waiting to hear back from the eye doctor's office regarding scheduling an appointment for eye laser treatment.
-He did not know if Resident #2 had any eye laser treatment done, or if they needed to be scheduled.
-He knew that the eye doctor gave a prescription for Resident #2 to get eye glasses.
-He acknowledged that he was given Resident #2's new eye glasses prescription, he gave it to

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C 249	Continued From page 28 the SIC and it was still filed away. -He forgot about Resident #2's prescription and getting it filled. -He knew that Resident #2 purchased a pair of sunglasses on 06/04/19. -He did not know that Resident #2 purchased the sunglasses to keep the light out of her eyes because she had been experiencing headaches, blurred vision, and eye pain. Interview with Administrator B on 06/06/19 at 2:10pm revealed: -She did not know Resident #2 had been to the eye doctor. -She did not know Resident #2 was given a prescription for eye glasses. -She did not know that Resident #2 received eye laser treatment. -She did not know Resident #2 purchased sunglasses on a facility outing on 06/04/19 and had been experiencing headaches, eye pain, and blurred vision. -Her expectations were for all residents appointments to be attended, prescriptions and treatment in a timely manner.	C 249		
{C 912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and service which were adequate,	{C 912}		

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{C 912}	Continued From page 29 appropriate, and in substantial compliance with relevant federal and state laws and rules and regulations as related to outside entrances and exits and personal care and supervision. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure 2 of 4 exit doors had sounding devices that were activated and sounded when the exit doors were opened to alert staff for 1 of 4 residents sampled (#2) who was constantly disoriented.[Tag C069 10A NCAC 13G. 0312(g) Outside Entrances and Exits (Unabated Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 4 residents sampled (#1, #3) with a documented histories of mental illness (#1, #3) and intellectual disability (#3) who were allowed to go to a creek and busy intersection unsupervised and the facility failed to provide supervision to 4 of 4 residents sampled (#1, #2, #3, #4) for at least thirty minutes during third shift on 06/06/19 for residents with a documented histories of mental illness (#1, #2, #3, #4) and intellectual disability (#3) as evidenced by staff reporting being unavailable to supervise the residents for at least 30 minutes while taking a shower behind four locked interior facility doors. [Tag C243 10A NCAC 13G.0901(b)Personal Care and Supervision (Type B Violation)].	{C 912}		