STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079098	A. BUILDING: ______ B. WING ______	R 12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KELLAM'S FAMILY CARE HOME	109 ROANOKE STREET REIDSVILLE, NC 27323

(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 December 16-17, 2015.	{C 000}		
{C 202}	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 sampled residents (#3) were tested upon admission for tuberculosis (TB) disease in compliance with control measures adopted by the Commission for Health Services. The findings are: Review of Resident #3's current FL-2 dated 10/26/15 revealed a diagnoses of schizophrenia disorder, bipolar and seizures. Review of Resident #3's Resident Register revealed an admission date of 10/12/15. Review of Resident #3's record revealed: -A physician order sheet dated 4/29/13 for TB skin test read negative on 4/29/13. -No additional documentation of any other TB	{C 202}		

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{C 202}	Continued From page 1 skin test. Interview on 12/16/15 at 9:00 am with Resident #3 revealed he had not had a TB skin test performed since he came to the facility. Interview on 12/16/15 at 2:30 pm with the Administrator revealed: -Resident #3 was admitted directly to the facility from a local family care home. -No TB test had been administered upon Resident #3's admission to the facility. -She had requested complete information from the former facility when the resident transferred to the current facility. -The information received from the former facility was incomplete for TB skin testing. -She had requested additional information for TB skin testing from the former facility, but had not received any information. -She felt certain Resident #3 had 2 TB skin tests because he resided at the former facility for 3 years. -She had not contacted the contract facility Nurse for administering a TB test for Resident #3. -Resident #3 had not seen the Primary Care Physician (PCP) for a TB skin test since admission. -She would contact the resident's PCP office to have a TB skin test placed. -The Administrator was responsible to assure residents admitted to the facility had proper the required TB testing.	{C 202}		
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	C 246		

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C 246	Continued From page 2 of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to notify the primary care physician for 1 of 3 sampled residents (Residents #3) for missed medications while out of the facility for extended leaves of absence. The findings are: Review of Resident #3's current FL-2 dated 10/26/15 revealed a diagnoses of schizophrenia disorder, bipolar and seizures. Review of Resident #3's Resident Register revealed the resident was listed as his own responsible person with no guardian or Power of Attorney. Review of Resident #3's medications verification dated 10/15/15 and current FL-2 dated 10/26/15 revealed physician orders included: -Clotrimazole-betamethasone cream (topical cream used to treat fungal irritation) apply to groin area 2 times a day. -Ketoconazole 2% cream (an antifungal cream) apply between toes daily. -Tamsulosin 0.4mg (used to treat benign prostatic hyperplasia) daily. -Dicyclomine 10 mg (used to treat bowel symptoms) 4 times daily. -Bupropion XL extended release 150 mg (used to treat mental disorders) every morning. -Trazadone 50 mg(used to treat mental disorders) every evening. -Divalproex 500mg (used to treat seizures) 2 tablets every evening. -Pantoprazole delayed release 40 mg (used to treat stomach acid reflux or ulcers) daily.	C 246		

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C 246	Continued From page 3 -Benztropine 0.5 mg (used to treat extrapyramidal symptoms) 2 times a day. Review of Resident #3's Medication Administration Records (MARs) for November 2015 revealed documentation for administration for clotrimazole-betamethasone cream, ketoconazole 2% cream, tamsulosin 0.4mg, dicyclomine 10 mg, bupropion XL extended release 150 mg, trazadone 50 mg, divalproex 500mg, pantoprazole delayed release 40 mg, and benztropine 0.5 mg as follows: -From 11/01/15 to 11/18/15 at 12:00 pm, the medications were documented for administered as ordered. -From 11/18/15 at 5:00 pm to 11/27/15 at 12:00 pm (10 days), the medications were documented not administered for "resident out of the facility ". -From 11/27/15 at 5:00 pm to 11/30/15 at 8:00 pm, the medications were documented for administered as ordered. Review of Resident #3's MARs for December 2015 revealed documentation for administration for clotrimazole-betamethasone cream, ketoconazole 2% cream, tamsulosin 0.4mg, dicyclomine 10 mg, bupropion XL extended release 150 mg, trazadone 50 mg, divalproex 500mg, pantoprazole delayed release 40 mg, and benztropine 0.5 mg as follows: -From 12/01/15 to 12/08/15 at 12:00 pm, the medications were documented for administered as ordered. -From 12/08/15 at 5:00 pm to 12/15/15 at 8:00 pm (8 days), the medications were documented not administered for reason "resident out of the facility". -On 12/16/15, the medications were documented as administered as ordered.	C 246		

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C 246	Continued From page 4 Review of Resident #3's record revealed no documentation for notification to the resident's primary care physician (PCP) or mental health provider that Resident #3 had not received medications as ordered from 11/17/15 at 5:00 pm to 11/27/15 at 5:00 pm (10 days), and from 12/08/15 at 5:00 pm to 12/15/15 at 8:00 pm (8 days). Review of a faxed document dated 12/16/15 from Resident #3's mental health provider revealed: -The medical staff was aware the resident had been away for a period of time at Thanksgiving (November 2015) and most recently for a week and returned on 12/16/15. -"We are aware that during this time the client did not take his prescribed medication". -"Client has been encouraged to take all medications as prescribed". Telephone interview on 12/16/15 at 2:08 pm with a representative at Resident #3's PCP office revealed: -Documentation on 12/10/15 for a phone called received from the facility Administrator to reschedule an appointment due to the resident not being at the facility. -No documentation of notification Resident #3 had missed 10 consecutive days of medication in November 2015. -No documentation of notification Resident #3 had missed 8 consecutive days of medications in December 2015. -The facility should notify the physician's office when a resident missed medications. (No specific number of missed medications specified.) Interviews on 12/16/15 at 1:30 pm and 12/17/15 at 9:55 am with Medication Aide/Supervisor in Charge (MA/SIC) revealed:	C 246		

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-The facility had a procedure in place to send residents' medications with the residents when going on extended leaves and routinely sent the medications.
-Residents were instructed to sign out of the facility when they left the facility and indicate when they were expected to return.
-Resident #3 signed out locally most every day.
-Resident #3's medications were not sent with the resident on 11/11/15 or 12/08/15 because Resident #3 did not indicate on the sign out sheet or inform the MA/SIC, when he signed out on 11/17/15 or 12/08/15, that he would be gone for more than a few hours.
-The MA/SIC informed the Administrator that Resident #3 was not in the facility and not receiving medications. (The MA/SIC was not certaain of the exact date she informed the Administrator.)
-She had not notified Resident #3's PCP or mental health provider for missed medications at either time.
-The Administrator would routinely be responsible for notifying the physicians and documenting notification of missed medications.

Interview on 12/16/15 at 2:22 pm with the Administrator revealed:
-Resident #3 routinely signed out of the facility most days.
-Resident #3 had been instructed to fill out the sign out sheet completely, including expected time back to the facility.
-Resident #3 did not indicate on 11/17/15 or 12/08/15 that he would not be returning to the facility the same day.
-Resident #3's PCP had not been notified for missing medications because Resident #3 missed a scheduled appointment with the PCP on 12/10/15 due to not being in the facility. The

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C 246	Continued From page 6	C 246		

appointment was rescheduled for January 2016.
-She was not aware of a facility policy for notification of residents' missed medications, but she would normally notify the prescriber after 2 missed doses.
-She had not notified Resident #3's PCP for medications not being administered during the November and December 2015 leaves of absence.

Interview on 12/17/15 at 9:05 am with Resident #3 revealed:
-He did not receive medications when he was away from the facility from 11/17/15 at 5:00 pm to 11/27/15 at 5:00 pm (10 days), and from 12/08/15 at 5:00 pm to 12/15/15 at 8:00 pm (8 days).
-He did not inform the facility he was going to be gone for more than one day for either of the times.
-He ended up staying longer than he had planned on each occasion.
-He had not experienced any adverse side effects (no seizures, no loss of sleep, or uncontrolled behaviors) or "gotten into any trouble" while he was off his medications.
-He had not missed receiving his long acting behavior injection from the mental health provider.

Telephone interview on 12/17/15 at 10:30 am with Resident #3's PCP Nurse revealed:
-The facility had notified the office that Resident #3 was not in the facility to attend an appointment scheduled for 12/10/15 and that the resident had been out of the facility for another extended period of time.
-Most of the resident's medications were followed by mental health provider.
-Medications related to mental health that were missed should be reported to the mental health

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C 246	Continued From page 7 provider. -The facility had not informed the Nurse that Resident #3 had not received medications while out of the facility.	C 246		
C 300	10A NCAC 13G .0906 (e) Other Resident Services 10A NCAC 13G .0906 Other Resident Services (e) Personal Lockable Space. (1) Personal lockable space must be provided for each resident to secure his personal valuables. One key shall be provided free of charge to the resident. Additional keys are to be provided to residents at cost upon request. It is not the home's obligation to pay for additional keys; and (2) While a resident may elect not to use lockable space, it must still be available in the home since the resident may change his mind. This space shall be accessible only to the resident and the administrator or supervisor-in-charge. The administrator or supervisor-in-charge must determine at admission whether the resident desires lockable space, but the resident may change his mind at any time. This Rule is not met as evidenced by: Based on observation, and interview, the facility failed to assure a personal lockable space was provided for each resident to secure his personal valuables related to items missing for one resident (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 06/18/15 revealed diagnoses included bipolar disorder mania with psychosis, and hypertension.	C 300		

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C 300	Continued From page 8 Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 06/18/15. Interview on 12/16/15 at 4:45 pm and 12/17/15 at 9:00 am with Resident #1 revealed: -Residents did not routinely go in other residents' room unless the rooms were shared with the resident. -He had been out of the facility with family members at Thanksgiving (11/26/15 and 11/27/15). -When Resident #1 returned from the facility he was missing several personal items from his room including a black leather coat, red thermal shirt, one pair of jeans, and a pair of boats. (Resident #1 stated he informed the facility Medication Aide/Supervisor in Charge.) -A resident was seen wearing the boots, which he asked to be returned. -Previously, the same resident was seen wearing a pair of Resident #1's jeans that were subsequently returned after being laundered due Resident #1's name labeled on an inside pocket. -He had since sold the boats (Brand Name) on the internet. -Resident #1 had not seen the black leather coat, red thermal shirt or jeans. -The lock on his bedroom door did not work, and he needed to have a lockable space available to put some of his items. -He was aware the facility should have a space he could lock up items because the other facilities he had been in had a lockable space with a key he kept. -A lock on his closet door would be nice, but he had not asked for one. Interview on 12/17/15 at 9:08 am with a housekeeper revealed:	C 300		

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C 300	Continued From page 9 -She worked mornings on Tuesday, Wednesday, and Thursday cleaning and mopping, with occasional laundry duty. -She was aware Resident #1 had a few personal items missing from his room because he had asked her "to be on the lookout" for the items. -Resident #1 had asked about a pair of boats, a pair of pants, and a leather coat specifically. -The housekeeper told the Administrator Resident #1 had reported items missing. -The residents' room have closets but no lockable space as far as she was aware. (Observation, on 12/16/15, of the three residents' rooms assigned to residents revealed no lockable space.) Interview on 12/17/15 at 9:12 am with the Medication Aide/Supervisor in Charge (MA/SIC) revealed: -She worked at the facility from Monday to Thursday night each week. -Resident #1 had reported to the MA/SIC he had items missing. -Residents' laundry was routinely washed separately, with the laundry basket delivered to her by the resident on wash day. -Resident #1 had his name in most of his clothes. -She had returned a pair of jeans with Resident #1's name on an inside pocket one time recently. (The jeans had gotten separated from Resident #1's regular wash). -She had not seen any other of the reported missing items. -She was not aware of a lockable space for each resident. -She had not seen residents looking around in other residents' room. -Resident #1 had not talked to the MA/SIC about any missing items. Interviews on 12/17/15 at 9:30 am and 12:30 pm	C 300		

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C 300	Continued From page 10	C 300		

with the Administrator revealed:
-The residents could ask the MA/SIC and she would lock any item they want locked up in the medication room.
-The facility had not had residents complaining about needing items locked up because no resident had informed her of items missing until recently.
-Resident #3 had requested to Resident #1 for him not to come back into his room.
-The facility had not had residents asking for items to be locked up before until recently.
-The Administrator had talked to Resident #1 and told Resident #1 to stay out of other residents' rooms.
-Resident #3 had told her he had items missing a while back.
-Resident #1 had not asked her for a lockable space.
-She was not aware that a lockable space had to be provided according to the family care rules.
-The residents' rooms did not have a lockable space.

Interview on 12/17/15 at 11:20 am with Resident #3 revealed:
-He had a lot of new clothes bought by family members that he was not wearing.
-He had not said anything to the Administrator about a lockable space but he needed one.
-He had spoken to Resident #1 about not coming in his room when he was not there.
-He had not experienced anything missing recently.

Telephone interview on 12/17/15 at with Resident #1's Power of Attorney revealed:
-Resident #1 had told her he had items missing at the facility in the past.
-The POA stated she was not aware of the items

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C 300	Continued From page 11 Resident #1 had reported as missing at Thanksgiving. -The POA stated she had purchased several clothing items for Resident #1 and some he had not worn yet. -The POA was not aware of Resident #1's need for a lockable space.	C 300		
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		

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C 301	Continued From page 12	C 301		

This Rule is not met as evidenced by:
Based on record review and interview, the facility failed to immediately notify the Department of Social Services and the appropriate law enforcement agency for 1 of 1 resident (Resident #3) whose whereabouts were unknown and there was reason to be concerned about the safety of the resident.

The findings are:

Review of Resident #3's current FL-2 dated 10/26/15 revealed a diagnoses of schizophrenia disorder, bipolar and seizures.

Review of Resident #3's Resident Register revealed the resident was listed as his own responsible person with no guardian or Power of Attorney (POA).

Review of Resident #3's Medication Administration Records (MARs) for November 2015 and December 2015 revealed:
-Documentation from 11/17/15 at 5:00 pm to 11/27/15 at 5:00 pm (10 days), medications were documented not administered for "resident out of the facility".
-Documentation from 12/08/15 at 5:00 pm to 12/15/15 at 8:00 pm (8 days), medications were documented not administered for "resident out of the facility".

Interviews on 12/16/15 at 1:30 pm and 12/17/15 at 9:55 am with Medication Aide/Supervisor in Charge (MA/SIC) revealed:

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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
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-The facility had a procedure in place to send residents' medications with the residents when going on extended leaves and routinely sent the medications.
-Residents were instructed to sign out of the facility when they left the facility and indicate when they were expected to return.
-Resident #3 signed out locally most every day.
-Resident #3's medications were not sent with the resident on 11/11/15 or 12/08/15 because Resident #3 did not indicate on the sign out sheet or inform the MA/SIC, when he signed out on 11/17/15 or 12/08/15, that he would be gone for more than a few hours.
-The MA/SIC informed the Administrator, the first day the resident did not return each time, that Resident #3 was not in the facility.

Interview on 12/16/15 at 2:22 pm with the Administrator revealed:
-Resident #3 was his own responsible person.
-Resident #3 routinely signed out of the facility most days.
-Resident #3 had been instructed to fill out the sign out sheet completely, including expected time back to the facility.
-Resident #3 did not indicate on 11/17/15 or 12/08/15 that he would not be returning to the facility the same day.
-Resident #3 had a personal cellular phone.
-Resident #3 had left the facility both times with a former resident of the facility.
-Resident #3 did not call the facility to let her know his whereabouts either time.
-The Administrator had left messages on the resident's cellular phone but had not received return calls.
-The Administrator had contacted the resident's family member (contact person) for information about Resident #3 in November 2015 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079098	A. BUILDING: ______ B. WING ______	R 12/17/2015

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C 301	Continued From page 14 December 2015. -In November, Resident #3 did not call until 11/27/15. -The Administrator and the MA/SIC had picked up Resident #3 in a nearby town on 11/27/15 after the resident called the facility stating he did not have a ride back to the facility. -In December, the Administrator spoke with the family member was informed that Resident #3 was not staying with the family member but had made contact with the family member to left family member know he was safe and staying a few days with a friend. -The Administrator stated she met Resident #3's family member in another nearby town early in the morning on 12/16/15 to pick up Resident #3 after the family arranged the pick-up. -The Administrator had not called the local law enforcement or Department of Social Services because the resident was his own responsible party and did not have a guardian or POA. Telephone interview on 12/16/15 at 4:12 pm with Resident #3's family member revealed: -The facility had informed the family member that Resident #3 was away from the facility and had not indicated on the sign-out sheet where the resident would be or how long the resident would be gone. -The family member was concerned that Resident #3 was away from the facility for several days on at least 2 occasions. -Resident #3 did not stay with the family member when he was away from the facility; both times he had been staying at a friend's place of residence. -The family member had been in the hospital around 11/23/15 and had not heard from the facility or the resident for several days until Resident #3 called her on 11/26/15 or 11/27/15 looking for a ride back to the facility.	C 301		

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-The family member was aware the Administrator picked Resident #3 up somewhere in the family member's home town on 11/27/15.
-The family member transported Resident #3 to meet the Administrator on 12/16/15 after Resident #3 contacted the family member for a ride back to the facility. (The friend that picked him up at the facility was unable to get the resident back to the facility.)
-When Resident #3 was off his medications, his hands were shaky and he was very restless; Resident #3 appeared that way when she saw him on 12/15/15 and she arranged to meet the Administrator on 11/27/15.

Interview on 12/17/15 at 9:20 am with Resident #3 revealed:
-He had left the facility both times with a friend.
-He did not inform the facility that he was going to be gone for more than one day for either of the times.
-He ended up staying longer than he had planned on each occasion.
-He had been in contact with a family member while he was out of the facility to let the family member know he was safe but not the facility because his cell phone stopped working.
-He had not experienced any adverse side effects (no seizures, no loss of sleep, or uncontrolled behaviors) or "gotten into any trouble" while he was off his medications and out of the facility.
-He liked staying at the facility because it was easy for him to see his friends.
- He was aware he was to sign in and out and to make the facility aware when he was coming back.

Review of the sign-out log revealed Resident #3 had signed out each time before leaving the facility, but had not indicated when he was

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