STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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 on 08/09/18.	C 000		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure that the licensed health professional support (LHPS) was completed quarterly for 2 of 2 sampled residents (Resident #1, #2) for the collecting and testing of finger stick blood sugars (FSBS) (#1 and #2) and medication administration through injection (#1).	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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 254	Continued From page 1 The findings are: 1. Review of Resident #1's current FL-2 dated 11/16/17 revealed: -Diagnoses included diabetes mellitus, paranoid schizophrenia, tobacco abuse, glaucoma, atherosclerosis of arteries and history of myocardial infarction. -There was a physician's order for daily FSBS. Review of Resident #1's LHPS evaluations and quarterly reviews revealed: -There was an LHPS evaluation completed on 10/24/17 with tasks for application and removal of prosthetic devices, medication administration through injections and collecting FSBS. -There was a LHPS quarterly review completed on 02/09/18 with no tasks checked. -Documentation revealed Resident #1 was independent with removing his prosthesis and his FSBS range was 62-250. -There was no quarterly review after 02/09/18. Review of physician's orders for Resident #1 dated 05/17/18 revealed an order for Novolog insulin, take 2 units three times daily as needed if blood sugar is greater than 150 and resident eats a meal; hold if resident does not eat. Interview with Resident #1 on 08/09/18 at 8:36am revealed: -He was independent with activities of daily living (ADL's) including transfers to and from his bed and wheelchair. -He used his walker or wheelchair for ambulation. -He had his blood sugar checked every day. -He got insulin shots, "sometimes, not every day". Interview with the Supervisor-in-Charge (SIC) on	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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 254	Continued From page 2 08/09/18 at 8:35am revealed: -Resident #1 was diabetic. -Resident #1's FSBS was checked three times a day. -Resident #1 received insulin injections based on the physician's orders. -Resident #1 was independent with his ADL's and transfers. Refer to interview with the Administrator on 08/09/18 at 10:05am. Refer to telephone interview with the facility's pharmacy consultant on 08/09/18 at 12:31pm. 2. Review of Resident #2's current FL-2 dated 03/23/18 revealed: -Diagnoses included schizophrenia, hypertension, tardive dyskinesia, seizure disorder, dyslipidemia and diabetes. -There was an order to check finger stick blood sugar (FSBS) once daily. Review of Resident #2's LHPS evaluations and quarterly reviews revealed: -There was a LHPS quarterly review completed on 10/24/17 with a task for collecting and testing FSBS -There was a LHPS quarterly review completed on 02/09/18 with a task for collecting and testing FSBS. -There was no quarterly review after 02/09/18. Interview with the Supervisor-in-Charge (SIC) on 08/09/18 at 8:35am revealed: -Resident #2 was diabetic. -Resident #2's FSBS was checked once a day. Interview with Resident #2 on 08/09/18 at 8:55am revealed:	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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 254	Continued From page 3 -He was independent with his activities of daily living. -He had a walker but did not use it "all the time". -He had his blood sugar checked every day. -He did not take a shot for his diabetes. Refer to interview with the Administrator on 08/09/18 at 10:05am. Refer to telephone interview with the facility's pharmacy consultant on 08/09/18 at 12:31pm. Interview with the Administrator on 08/09/18 at 10:05am revealed: -He was responsible for obtaining initial and quarterly reviews for residents who had LHPS tasks. -He had talked to the previous LHPS nurse in May/June 2018 when the quarterly reviews were due. -The previous LHPS nurse was having medical problems and told him she would be able to complete the reviews "soon." -He talked to the previous LHPS nurse again in July, and she thought she was going to be able to complete the LHPS quarterly reviews but had not been in. -He realized the previous LHPS nurse was not going to be able to come in to complete the LHPS reviews, and he therefore talked to the facility's pharmacy consultant about the need for LHPS reviews. -No date had been confirmed for the LHPS reviews to be completed by the pharmacy consultant. -He would have the LHPS reviews completed as soon as possible. Telephone interview with the facility's pharmacy consultant on 08/09/18 at 12:31pm revealed:	C 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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 254	Continued From page 4 -The Administrator had talked with her several months ago, maybe May or June (date unknown) about doing the LHPS reviews. -The Administrator said he would call her to let her know if he needed her to complete the LHPS reviews; she had not had any further communication with the Administrator about the LHPS reviews.	C 254		
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 home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled medication aides (Staff C) completed the state mandated annual infection control course. The findings are:	C 934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017008	A. BUILDING: _____ B. WING _____	08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEY CREEK FAMILY CARE HOME	2896 STONEY CREEK SCHOOL ROAD REIDSVILLE, NC 27320

(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 934	Continued From page 5 Review of Staff C, Supervior-in-Charge's, personnel record revealed: -Staff C was hired on 07/16/13. -There was documentation that the state annual infection control training was completed on 11/26/14. -There was no documentation Staff C completed the state annual infection control training after 11/26/14. Interview with the Administrator on 08/09/18 at 4:21pm revealed: -Staff C worked as a SIC at the facility. -He was responsible to ensure all staff training was completed as required. -He audited staff records 2-3 months ago. -He thought Staff C had the annual infection control training; he would have to look for the certificate. -He would schedule Staff C for infection control training as soon as possible if he could not locate a current certificate. Attempted interview with Staff C on 08/09/18 at 4:42pm was unsuccessful.	C 934		