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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079019	A. BUILDING: SEP 25 2019 B. WING ADULT CARE LICENSURE SECTION RALEIGH	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD FAMILY CARE HOME	511NC HIGHWAY 87 REIDSVILLE, NC 27320

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C 000	Initial Comments The Adult Care Licensure Section cconducted an anual survey on 09/05/19 with a telephone exit on 09/06/19.	C 000		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure 1 of 2 sampled staff (Staff B) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff B's, Administraotor, personnel record revealed: -There was no hire date for Staff B. -Staff B also worked as a medication aide (MA). -There was no documentation of Staff B having a HCPR check prior to or upon hire. Interview with Staff B on 09/05/19 at 4:36pm revealed: -He had been operating the facility for over 30 years as Administrator and a MA. -He did not remember if he or the co-Administrator had checked the HCPR for him upon hire or anytime afterwards.	C 145	10ANCAC 13G.0406(a)(5) Staff A Will Contact NC Health Care Personel Registry To Obtain findings for Staff B Staff A will Monitor The Administrators will be responsible for contacting HCPR and monitoring. Keisha Banks 10/15/19	9-30-19

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Edith Blackwell
TITLE: Administrator
(X6) DATE: 9/22/19

STATE FORM 6899 GSNL11

Addendums: p.1, 2, 5, 9, and 12. Reviewed and Accecpted Keisha Banks 10/15/19

PRINTED: 09/11/2019
FORM APPROVED

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C 145	Continued From page 1 Interview with the co-Administrator on 09/05/19 at 4:30pm revealed: -She was responsible for checking the HCPR. -Staff B had operated the facility by himself initially in 1987. -She and Staff B had been the only staff over the last 32 years. -She thought the HCPR had been checked for Staff B, but she could not find the documentation.	C 145		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health 10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 2 of 2 (Staff A and B) who was non-licensed had been competency validated for Licensed Health Professional Support (LHPS) tasks including assistance with ambulation with assistive devices and transferring. The findings are:	C 171	10A NCAC 13G.0504 Competency Validation for Licensed Health. Staff will contact a registered Nurse to validate the competency of Staff A & B - The nurse will Complete form yearly thereafter. The Administrators will be responsible for contacting a registered nurse. Keisha Banks 10/15/19	10/30/19

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C 171	Continued From page 2	C 171		

Continued From page 2

1. Review of Staff A's, co-Administrator, personnel file revealed:
-There was no hire date for Staff A.
-Staff A also worked as a medication aide (MA).
-There was no LHPS competency validation checklist for Staff A.

Observation of a resident on 09/05/19 at 3:10pm revealed:
-Staff A took the resident's walker out to a van and placed the walker at the bottom of the van steps.
-The resident ambulated down the steps of the van holding on to the side rails and grabbed the walker to ambulate to the steps of the facility.
-Staff A handed the walker up the steps of the facility to another resident who placed the walker in the doorway at the top of the steps.
-The resident ambulated up the steps using the handrail, grabbed the walker in the doorway at the top of the steps, and ambulated independently with his walker to his bedroom.

Interview with the resident on 09/05/19 at 3:36pm revealed:
-He mainly used his walker to ambulate.
-He sometimes used his wheelchair on outings.
-When he had to use his wheelchair, staff had to propel him in the wheelchair.
-He thought he started using his walker about 5 years ago and obtained the wheelchair after that.

Interview with Staff A on 09/05/19 at 4:30pm revealed:
-She had worked at the facility since 1987.
-She assisted one resident at the facility with transferring from couches and ambulation with a walker and wheelchair.
-She did not have a LHPS validation completed by a nurse because she did not think she needed

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C 171	Continued From page 3	C 171		

one.
-A nurse had not observed or checked her off on performing LHPS tasks.
-The facility did not currently have an LHPS nurse.

Interview with the Administrator on 09/05/19 at 4:36pm revealed:
-Staff A was hired as a medication aide and co-Administrator.
-There was one resident in the facility who required assistance with ambulation using a walker and a wheelchair.
-He did not know a LHPS validation was needed for staff when there was a resident in the facility who needed assistance with ambulation and transfers using a walker and a wheelchair.

2. Review of Staff B's, Administrator, personnel record revealed:
-There was no hire date for Staff B.
-Staff B also worked as a medication aide (MA).
-There was no LHPS competency validation checklist for Staff A.

Interview with Staff B on 09/05/19 at 4:36pm revealed:
-He had been operating the facility for over 30 years as Administrator and a MA.
-He did not remember if an LHPS validation was completed for him.
-He did not know an LHPS validation was needed for staff if a resident required assistance with transfers and ambulation using a walker and wheelchair.

Interview with the co-Administrator on 09/05/19 at 4:30pm revealed:
-There was one resident in the facility who required assistance with ambulation using a

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C 171	Continued From page 4 walker and a wheelchair and occasionally required assistance with transfers. -Staff B did not have a LHPS validation completed because she did not think he needed one due to the resident not having an LHPS need when he was admitted to the facility. -Staff B had not been observed or checked off by a nurse on performing LHPS tasks. -The facility did not currently have an LHPS nurse.	C 171		
C 252	10A NCAC 13G .0903(a) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (a) A family care home shall assure that an appropriate licensed health professional, participates in the on-site review and evaluation of the residents' health status, care plan and care provided for residents requiring one or more of the following personal care tasks: (1) applying and removing ace bandages, ted hose, binders, and braces and splints; (2) feeding techniques for residents with swallowing problems; (3) bowel or bladder training programs to regain continence; (4) enemas, suppositories, break-up and removal of fecal impactions, and vaginal douches; (5) positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter; (6) chest physiotherapy or postural drainage; (7) clean dressing changes, excluding packing wounds and application of prescribed enzymatic debriding agents; (8) collecting and testing of fingerstick blood samples;	C 252	10A NCAC 13G.0903(a) Licensed Health professional Support. A licended health care Professional will complete an onsite evalation of Resident health Status. Staff will contract with nurses. The nurse will complete forms quarterly. The Adminstrators will be responsible for contacting a registered nurse to complete the LHPS for resident. Keisha Banks 10/15/19	10-1-19

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C 252	Continued From page 5 (9) care of well-established colostomy or ileostomy (having a healed surgical site without sutures or drainage); (10) care for pressure ulcers, up to and including a Stage II pressure ulcer which is a superficial ulcer presenting as an abrasion, blister or shallow crater; (11) inhalation medication by machine; (12) forcing and restricting fluids; (13) maintaining accurate intake and output data; (14) medication administration through a well-established gastrostomy feeding tube (having a healed surgical site without sutures or drainage and through which a feeding regimen has been successfully established); (15) medication administration through injection; Note: Unlicensed staff may only administer subcutaneous injections as stated in Rule .1004(q) of this Subchapter; (16) oxygen administration and monitoring; (17) the care of residents who are physically restrained and the use of care practices as alternatives to restraints; (18) oral suctioning; (19) care of well-established tracheostomy, not to include indo-tracheal suctioning; (20) administering and monitoring of tube feedings through a well-established gastrostomy tube (see description in Subparagraph (14) of this Paragraph); (21) the monitoring of continuous positive air pressure devices (CPAP and BIPAP); (22) application of prescribed heat therapy; (23) application and removal of prosthetic devices except as used in early post-operative treatment for shaping of the extremity; (24) ambulation using assistive devices that requires physical assistance; (25) range of motion exercises;	C 252		

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(26) any other prescribed physical or occupational therapy;
(27) transferring semi-ambulatory or non-ambulatory residents; or
(28) nurse aide II tasks according to the scope of practice as established in the Nursing Practice Act and rules promulgated under that act in 21 NCAC 36.

This REQUIREMENT is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to assure a quarterly Licensed Health Professional Support (LHPS) evaluation had been completed by an appropriate licensed health professional for 1 of 3 sampled residents (Resident #1).

The findings are:

Review of Resident #1's current FL2 dated 04/09/19 revealed:
-Diagnoses included athetoid cerebral palsy, obesity, and chronic pain syndrome
-Resident #1 was semi-ambulatory.
-There were no assistive devices listed on the FL2.

Review of Resident #1's assessment and care plan dated 04/28/19 revealed:
-The box was blank for indication of need for assistance with ambulation, and transfer.
-Under the section titled "Other: (Include LHPS Personal Care Tasks)," the word prompting was written; No LHPS tasks were listed.

Review of Resident #1's record revealed there was no LHPS evaluation available for review.

Review of an Independent Assessment for

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C 252	Continued From page 7 Personal Care Services dated 05/07/19 revealed there was documentation staff assisted resident with getting out of bed in the morning. Interview with the co-Administrator on 09/05/19 at 12:51 pm revealed: -Resident #1 did not need assistance with ambulation when he was first admitted to the facility in 1987. -Resident #1 did not develop a need for assistive devices until 2 to 3 years ago. -Resident #1 used his walker daily and used his wheelchair when they went on outings that required a lot of walking. -Staff assisted with setting up the wheelchair and walker and sometimes assisted Resident #1 with transferring up from his wheelchair and from low furniture. -She was responsible for making sure the LHPS was completed for residents. -She did not have an LHPS completed for Resident #1 because she did not think it needed to be completed since Resident #1 was admitted to the facility without any LHPS tasks. Observation of Resident #1 on 09/05/19 at 3:10pm revealed: -Staff A took the resident's walker out to a van and placed the walker at the bottom of the van steps. -The resident ambulated down the steps of the van holding on to the side rails and grabbed the walker to ambulate to the steps of the facility. -Staff A handed the walker up the steps of the facility to another resident who placed the walker in the doorway at the top of the steps. -Resident #1 ambulated up the steps using the handrail, grabbed the walker in the doorway at the top of the steps, and ambulated independently with his walker to his bedroom.	C 252		

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C 252	Continued From page 8 Interview with Resident #1 on 09/05/19 at 3:36pm revealed: -He mainly used his walker to ambulate. -He sometimes used his wheelchair on outings. -When he had to use his wheelchair, staff had to propel him in the wheelchair. -He thought he started using his walker about 5 years ago and obtained the wheelchair after that. Second interview with the co-Administrator on 09/05/19 at 5:03pm revealed: -Resident #1 had a walker for about 3 years and a wheelchair for about 2 years. -Staff propelled Resident #1 in his wheelchair when he used it.	C 252		
C 270	10A NCAC 13G .0904 (c-7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have a matching therapeutic diet menu for staff guidance for 1 of 1 sampled resident (Resident #3) who had physician's instructions to follow a high fiber diet. The findings are: Review of Resident #3's current FL2 dated 11/28/18 revealed:	C 270	10A NCAC 13G.0904(C-7) Nutrition and Food Service Facility received a high fiber diet guide from the physician which indicated which foods were high in fiber serving sizes and how much fiber in each serving. Posted in kitchen 9-12-19. The facility will have matching therapeutic diets Residents will be informed of any special diets prescribed by physician with diets posted.	11-1-19 11-1-19

The Administrators will contact a registered dietician to review and approved the hig fiber diet menu.

Keisha Banks 10/15/19

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C 270	Continued From page 9	C 270		

Continued From page 9

-Diagnoses included gastroesophageal reflux disease, hyperlipidemia, and mild mental retardation.
-There was an order for a regular diet.

Review of an After Visit Summary dated 08/28/19 from Resident #3's gastroenterologist revealed:
-Resident #3 was seen on 08/28/19 for gastroesophageal reflux disease, slow constipation, and other chronic gastritis.
-There were physician's instructions to follow a high fiber diet.

Observation of the kitchen on 09/05/19 between 8:45am and 9:00am revealed:
-There was no therapeutic diet list posted.
-There was a regular diet menu posted on the wall.
-There was no therapeutic menu for a high fiber diet posted in the kitchen.

Review of the facility's menu notebook revealed there were regular and therapeutic diet menus available, but there was no therapeutic diet menu available for a high fiber diet.

Observation of the dinner meal on 09/05/19 between 5:15pm and 5:25pm revealed Resident #3 was served baked chicken, peas, broccoli, a slice of toast, applesauce, water and milk.

It could not be determined if Resident #3 was served the appropriate meals due to no therapeutic menu available for a high fiber diet for staff guidance.

Interview with the co-Administrator on 09/05/19 at 9:00am revealed all residents were on a regular diet.

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C 270	Continued From page 10	C 270		

Second interview with the co-Administrator on 09/05/19 at 10:47am revealed:
-She had purchased the notebook of menus more than 20 years ago and it did not include a menu for a high fiber diet.
-She knew about the gastroenterologist's instructions for Resident #3 to follow a high fiber diet, but she thought giving Resident #3 fiber supplements and making sure he had cereal with fiber would be enough.
-She should have checked with the physician to see what kind of high fiber diet Resident #3 was to follow.
-She had not consulted a registered dietician regarding a menu for a high fiber diet.
-She had been serving Resident #3 a regular diet.

Interview with Resident #3 on 09/05/19 at 2:20pm revealed:
-He ate the same meals as the other residents in the facility.
-He had never been told he needed to be on a special diet.
-He did not know if he was receiving a high fiber diet.
-He had lunch from a restaurant on today, 09/05/19 which consisted of a chicken sandwich, cookies, milk, and water.

Interview with a nurse from Resident #3's gastroenterologist's office on 09/05/19 at 2:22pm revealed:
-Resident #3 was seen by the gastroenterologist on 08/28/19 for gastrointestinal reflux disease, constipation and gastritis.
-Resident #3 was seen previously by the gastroenterologist on 11/19/18 and on 02/19/19 for gastrointestinal issues.
-Resident #3 should be on a high fiber diet daily consisting of 38-40 grams of fiber.

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C 270	Continued From page 11 -She would send a guide to the facility which indicated which foods were high in fiber, serving sizes, and how much fiber in each serving.	C 270		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the medication administration records (MAR) were accurate and complete for 1 of 3 sampled residents (Resident #3) related to a fiber supplement and a proton pump inhibitor. The findings are:	C 342	10ANCAC 13G.1004(j) Medication Administration Staff will take FL-2 to physician for completion. Henceforth all physicians orders will be taken to the pharmacy and added to the MAR for each residents. All over the counter items will be taken to the Pharmacy. MAR will be check for accuracy. The Administrators will be responsible for taking FL2s to the physician for completion and for monitoring. Keisha Banks 10/15/19-	9/9/19

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C 342	Continued From page 12 Review of Resident #3's current FL2 dated 11/19/18 revealed diagnoses included gastroesophageal reflux disease, hyperlipidemia, and mild mental retardation. a. Further review of Resident #3's current FL2 dated 11/19/18 revealed there was a physician's order for fiber (a supplement used to treat constipation or bowel irregularity) to be administered 1 scoop daily. Review of a subsequent physician's order dated 08/28/19 revealed an order to continue fiber supplements. Review of the facility's daily documentation for Resident #3 from November 2018 through January 2019 revealed: -There was an entry for fiber powder 1 scoop daily with water at 9:00am. -Fiber powder was documented as administered daily at 9:00am from 11/20/19 through 01/31/19. -There was no documentation for the administration of fiber powder after 01/31/19. Review of Resident #3's Medication Administration Record (MAR) for February, March, April, May, June, July, and August 2019 revealed there was no entry for fiber powder 1 scoop daily. Observation of Resident #1's medications on hand on 09/05/19 at 11:14am revealed: -There was container of over the counter (OTC) fiber powder available for administration. -The container of fiber powder was not labeled with Resident #1's name or instructions for administration for Resident #1. -The directions on the container label read, "Put 1	C 342		

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	FCL079019	A. BUILDING: ______ B. WING ______	09/06/2019

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rounded tablespoon into an empty glass and mix with 8 ounces of liquid up to 3 times daily for daily fiber supplement; 3 times daily to help maintain healthy blood sugar levels and for cholesterol lowering to promote heart health.

Interview with Resident #3 on 09/05/19 at 2:20pm revealed he received fiber powder in water daily.

Interview with the co-Administrator on 09/05/19 at 10:38am revealed:
-She usually took a physician's order form to the physician's office when a resident had a medical appointment.
-She followed any new physician's order, but did not take the new physician's order to the pharmacy to be added to the MAR.
-She did not take the updated FL2s to the pharmacy to be added to the MAR.
-Resident #3's gastroenterologist told her to buy OTC fiber powder to give to Resident #3.
-She bought over the counter fiber powder and had been giving Resident #3 one tablespoon in 8 ounces of water daily starting in November 2018.
-She had not taken the physician's order for fiber powder dated 11/19/18 or 08/28/19 to the pharmacy.
-She knew the fiber powder was not on Resident #3's MAR.
-She had been administering the fiber powder to Resident #3, but she had not been documenting administration of fiber powder anywhere since 01/31/19.

Interview with a representative at the contracted pharmacy on 09/05/19 at 11:03am revealed the pharmacy had not received a physician's order for fiber powder for Resident #3.

b. Review of Resident #3's current FL2 dated

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11/28/18 revealed there was an order for omeprazole 20mg twice daily (a proton pump inhibitor used to treat gastroesophageal reflux disease and esophagitis).

Review of a subsequent physician's order dated 08/28/19 revealed an order to continue omeprazole 30 minutes prior to meals once or twice daily.

Review of an After Visit Summary dated 08/28/19 from Resident #3's gastroenterologist revealed:
-Resident #3 was seen on 08/28/19 for gastroesophageal reflux disease, slow constipation, and other chronic gastritis.
-There were instructions to continue omeprazole 30 minutes prior to meals once or twice daily to prevent uncontrolled heart burn, ulcers, and gastritis due to daily aspirin use.

Review of Resident #3's August 2019 Medication Administration Record (MAR) revealed:
-There was an entry for omeprazole 20mg 1 capsule twice daily and scheduled for administration at 7:00am and 4:00pm.
-Omeprazole 20mg was documented as administered daily at 7:00am and 4:00pm from 08/01/18 through 08/27/18.
-Omeprazole 20mg was documented as administered daily at 7:00am from 08/28/19 through 08/31/19.
-The 4:00pm entry on 08/28/19 had a line through it and the letters, DC (discontinued), were written below the line.
-There was no documentation of administration of omeprazole 20mg at 4:00pm from 08/28/19 through 08/31/19

Review of Resident #3's September 2019 MAR revealed:

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C 342	Continued From page 15 -There was an entry for omeprazole 20mg 1 capsule twice daily and scheduled for administration at 7:00am and 4:00pm. -Omeprazole 20mg was documented as administered daily at 7:00am from 09/01/19 through 09/05/19. -There was no documentation of administration of omeprazole 20mg at 4:00pm on 09/01/19 through 09/05/19. Observation of Resident #3's medications on hand on 09/05/19 at 11:07am revealed: -Omeprazole 20mg 1 capsule twice daily was available for administration. -The printed pharmacy label dated 08/14/19 with Resident #2's name had instructions to administer omeprazole 20mg twice daily before meals. -Thirty-one capsules of the 7:00am dose of omeprazole 20mg were dispensed on 08/14/19 with 21 capsules remaining. -Thirty-one capsules of the 4:00pm dose of omeprazole 20mg were dispensed on 08/14/19 with 30 capsules remaining. Interview with the co-Administrator on 09/05/19 at 10:38am revealed: -Omeprazole was ordered for Resident #3 by his gastroenterologist. -She attended the appointment with Resident #3 when he was seen by the gastroenterologist on 08/28/19. -The gastroenterologist told her she wanted Resident #3 to take omeprazole 20mg once daily. -She did not take the order written by the gastroenterologist on 08/28/19 for omeprazole to the pharmacy to update the MAR. -She documented administration of omeprazole at 7:00am because she only administered the 7:00am dose.	C 342		

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C 342	Continued From page 16 -She did not know why she did not take the order for omeprazole to the pharmacy or change it on the MAR. Interview with a representative from the contracted pharmacy on 09/05/19 at 11:03am revealed: -There was an order dated 11/19/19 for omeprazole 20mg twice daily before meals. -The pharmacy had not received any new orders or changes in the order to omeprazole. -If the pharmacy had received an order dated 08/28/19 for omeprazole 20mg once or twice daily, they would have clarified the order with the physician and added it to the MAR. Interview with Resident #2 on 09/05/19 at 2:20pm revealed he thought he received 3 tablets in the morning and 1 tablet in the evening. Interview with a nurse at Resident #3's gastroenterologist office on 09/05/19 at 2:22pm revealed: -There was an order written on 08/28/19 to continue omeprazole once or twice daily. -Resident #3 should be administered omeprazole 20mg 1 capsule once daily.	C 342		