

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL073012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2021
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NAME OF PROVIDER OR SUPPLIER LOVING TOUCH FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5975 BOSTON ROAD ROXBORO, NC 27574
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 9, 2021.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the	C 007		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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C 007	<p>Continued From page 1</p> <p>building.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that residents' evacuation capabilities were different from the evacuation capabilities listed on the facility's license.</p> <p>The findings are:</p> <p>Review of the facility's license effective January 1, 2021 revealed the facility was licensed for a capacity of six ambulatory residents.</p> <p>Observation of the facility on 04/09/21 at 8:30am revealed the facility was not equipped with a sprinkler system.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 04/09/21 at 7:30am revealed there were four residents that resided at the facility.</p> <p>Telephone interview with the Administrator on 04/09/21 at 3:37pm revealed: -She was planning on moving Resident #3 to an Assisted Living facility prior to the COVID-19 pandemic but it "never happened". -She was concerned about how Resident #3 could not "do for herself" anymore. -The staff were trained not to assist residents during fire drills and should not prompt or say "come on" to the residents. -The residents were all supposed to know to get up and exit the facility on their own during a fire</p>	C 007		

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C 007	Continued From page 2 drill. -She was not aware Resident #3 could not exit the facility during a fire drill without the staff coaxing her. -She had not notified construction about Resident #3 not being able to exit on her own during a fire drill. -She was not aware she needed to notify the Division of Health Service Regulation (DHSR) if the overall capability of a resident changed from the one listed on the license. Refer to Tag C022 10A NCAC 13G .0302(b) Design and Construction (Type B Violation).	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's license for 1 of 1 sampled resident (#3) residing in the facility with cognitive impairments which could prevent the resident from evacuating the facility independently.	C 022		

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C 022	<p>Continued From page 3</p> <p>The findings are:</p> <p>Review of the facility's current license effective January 1, 2021 revealed the facility was licensed for a capacity of six ambulatory residents.</p> <p>Review of the facility's census revealed there were four residents that resided at the facility and two staff working during the day and one staff in the evening.</p> <p>Review of Resident #3's FL-2 dated 07/14/20 revealed: -Diagnoses included dementia with depression, coronary artery disease, cerebrovascular accident, and degenerative joint disease. -Resident #3 was semi-ambulatory and used a walker.</p> <p>Review of Resident #3's care plan dated 11/03/20 revealed: -Resident #3 needed supervision with ambulation/locomotion and transferring. -Resident #3 needed limited assistance with eating, toileting and dressing. -Resident #3 needed extensive assistance with bathing and grooming.</p> <p>Observation of Resident #3 on 04/09/21 at 10:00am revealed the Supervisor-in-Charge (SIC) guided Resident #3 to the dining room by placing one hand on the resident's walker and verbally prompted the resident down the hall and into the seat.</p> <p>Observation of Resident #3 on 04/09/21 at 12:00pm revealed she was not responding to the medication aide's (MA's) cues to eat and was humming.</p>	C 022		

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C 022	<p>Continued From page 4</p> <p>Observation of a fire drill conducted by the SIC and the MA on 04/09/21 revealed:</p> <ul style="list-style-type: none"> -At 2:11pm the SIC activated the the alarm for the fire drill. -Resident #3 was seated in a chair in the living room humming. -Resident #3 did not respond to the fire drill but continued to sit in the chair and hum. -The MA and the other residents exited the facility in two minutes and met at the birdbath. -All the residents and the staff were standing at the designated meeting spot in the yard except Resident #3. -The SIC activated the alarm a second time at 2:15pm; Resident #3 continued to sit in the chair and did not respond. -Resident #3 never left the facility. <p>Review of the facility's fire drill logs revealed:</p> <ul style="list-style-type: none"> -Fire drills were conducted monthly from 12/2020-03/2021 between the hours of 2:30pm and 9:30pm. -The length of time for evacuation during the fire drills was from two minutes to two and a half minutes. -The last documented fire drill was on 03/15/21 at 9:30pm and took two and a half minutes. <p>Interview with a resident on 04/09/21 at 1:04pm revealed:</p> <ul style="list-style-type: none"> -Every month or two, the staff surprised them with a fire drill. -She just exited the facility on her own and did not help any other residents to leave during a fire drill. -The staff would help Resident #3 during the fire drill. -The staff would verbally and physically help Resident #3 get out of the facility during the fire drill. 	C 022		

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C 022	<p>Continued From page 5</p> <p>-The staff did not have to help any other residents exit during the fire drill.</p> <p>Interview with a second resident on 04/09/21 at 1:08pm revealed:</p> <p>-The staff had a fire drills but not once a month .</p> <p>-During her first fire drill she was told by the SIC to go through the nearest door and to meet at the birdbath in the back yard.</p> <p>-She did not have to help anyone out of the facility because the staff were right there and were the last ones out of the facility.</p> <p>-Staff always helped Resident #3 during the fire drills because she got confused.</p> <p>-Staff would escort Resident #3 out of the facility by talking to her and guiding her by her walker towards the door and out of the facility.</p> <p>-Staff were constantly telling Resident #3 where to go and what to do.</p> <p>Interview with the SIC on 04/09/21 at 11:59am revealed:</p> <p>-Resident #3 was very confused and then very clear at times; sometimes could understand and sometimes not understand what was going on.</p> <p>-Resident #3 could understand simple commands and cues.</p> <p>Second interview with the SIC on 04/09/21 at 12:57pm revealed:</p> <p>-Fire drills were conducted and documented once a month.</p> <p>-The fire drills were conducted on all three shifts.</p> <p>-Staff would manually set the alarm to go off, the resident would exit the facility, and everyone would meet the designated spot in the back yard.</p> <p>-Most of the residents came out of the facility on their own; some of the residents were slower than others.</p> <p>-Resident #3 took longer to exit than the other</p>	C 022		

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C 022	<p>Continued From page 6</p> <p>residents because she was slow.</p> <ul style="list-style-type: none"> -She did not cue or assist any of the residents to exit during the fire drill, even the slow ones. -Sometimes the other residents helped Resident #3 by cueing her to exit during the drill. <p>Interview with the MA on 04/09/21 at 2:17pm revealed:</p> <ul style="list-style-type: none"> -The staff conducted fire drills once a month . -The staff would pull the alarm and when the residents would look at her, she would tell them it was a fire drill. -Everyone could get out on their own. -Resident #3 could move on her own but did not recognize what was happening if was a fire drill going on. -Resident #3 could not recognized a fire drill was happening but she would see the other residents exiting she would follow them out on her own. -Resident #3 grinned a lot but did not understand what was going on; she could get Resident #3 "going" during a fire drill by "coaxing" her. <p>Telephone interviews with the Administrator on 04/09/21 at 2:43pm and 3:37pm revealed:</p> <ul style="list-style-type: none"> -She was planning on moving Resident #3 to an Assisted Living facility prior to the COVID-19 pandemic. -She was concerned about how Resident #3 could not "do for herself" anymore. -She could not say if there was a progresive decline of Resident #3's dementia. -The staff were trained not to assist residents during fire drills and should not prompt or say "come on" to the residents. -The residents were all supposed to know to get up and exit the facility on their own during a fire drill. -She was not aware Resident #3 could not exit the facility during a fire drill without staff 	C 022		

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C 022	<p>Continued From page 7</p> <p>assistance and or prompting. -Staff should have told her they had to help Resident #3 to exit.</p> <p>Attempted interview with Resident #3's primary care provider (PCP) on 04/09/21 at 3:56pm were unsuccessful.</p> <p>Based on observations, interviews, and record reviews it was determined Resident #3 was not interviewable.</p> <p>_____</p> <p>The facility failed to ensure Resident #3 who had a diagnosis of dementia was able to evacuate the facility in an emergency without physical or verbal prompting by staff. This failure was detrimental to the health and safety of the resident and constitutes a Type B violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/09/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 24, 2021.</p>	C 022		
C 912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents</p>	C 912		

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C 912	<p>Continued From page 8</p> <p>received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to facility fire safety.</p> <p>The Findings are:</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure the building was equipped and maintained for 1 of 3 sampled residents (#3) residing in the facility who had cognitive impairments and was unable to evacuate the facility independently. [Refer to Tag C022, 10A NCAC 13G .0302 (b) Design and Construction (Type B Violation)].</p>	C 912		