STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING:			(X3) DATE SURVEY COMPLETED	
		7.1. 56.125.1.16. <u> </u>			С	
	FCL078079	B. WING		05	/31/2019	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
MILY CARE HOME #10						
(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETE DATE	
Initial Comments		C 000				
County Department o	f Social Services conducted					
10A NCAC 13G .0302 Construction	2 (b) Design And	C 022				
10A NCAC 13G .0302	2 Design And Construction					
(b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home.						
TYPE B VIOLATION Based on observation reviews, the facility fa was equipped and ma sampled (#1, #2, #3, and/or cognitively una independently. The findings are: Review of the facility's 01/01/19 revealed the total residents; with a non-ambulatory residents.	as, interviews, and record iled to assure the building aintained for 5 of 6 residents #4, #6) who were physically able to evacuate the facility able to evacuate the facility as current license effective a facility was licensed for 6 maximum of 3 ents.					
	ROVIDER OR SUPPLIER MILY CARE HOME #10 SUMMARY STI (EACH DEFICIENCY REGULATORY OR LE Initial Comments The Adult Care Licens County Department of an annual survey from 2019. 10A NCAC 13G .0302 Construction 10A NCAC 13G .0302 (b) Each home shall equipped and maintain offered in the home. This Rule is not met an annual survey from 2019. This Rule is not met and the facility factor was equipped and maintain offered in the home. The findings are: Review of the facility's 01/01/19 revealed the total residents; with a non-ambulatory residents. Review of the daily contained th	FCL078079 ROVIDER OR SUPPLIER STREET A 70 CARE PEMBRO SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services conducted an annual survey from May 29, 2019 - May 31, 2019. 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, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 5 of 6 residents sampled (#1, #2, #3, #4, #6) who were physically and/or cognitively unable to evacuate the facility independently.	ROVIDER OR SUPPLIER FCL078079 STREET ADDRESS, CITY, STATE MILY CARE HOME #10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments C 000 Initial Comments C 000 Initial Comments The Adult Care Licensure Section and Robeson County Department of Social Services conducted an annual survey from May 29, 2019 - May 31, 2019. 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, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 5 of 6 residents sampled (#1, #2, #3, #4, #6) who were physically and/or cognitively unable to evacuate the facility independently. The findings are: Review of the facility's current license effective 01/01/19 revealed the facility was licensed for 6 total residents; with a maximum of 3 non-ambulatory residents. Review of the daily census revealed 6 residents	ROUIDER OR SUPPLIER FCL078079 STREET ADDRESS, CITY, STATE, ZIP CODE 70 CARE DRIVE PEMBROKE, NC 28372 SUMMARY STATEMENT OF DEFICIENCES [EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments C 000 Initial Comments C 000 The Adult Care Licensure Section and Robeson County Department of Social Services conducted an annual survey from May 29, 2019 - May 31, 2019. 10A NCAC 13G .0302 (b) 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, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 5 of 6 residents sampled (#1, #2, #3, #4, #6) who were physically and/or cognitively unable to evacuate the facility independently. The findings are: Review of the facility's current license effective 01/10/119 revealed the facility was licensed for 6 total residents; with a maximum of 3 non-ambulatory residents. Review of the daily census revealed 6 residents Review of the daily census revealed 6 residents Review of the daily census revealed 6 residents Review of the daily census revealed 6 residents	FOURSECTION IDENTIFICATION NUMBER: A BUILDING: COMMITTED C	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B WING		С	
		FCL078079	B. WING		05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE I				
		KE, NC 28372				
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 022	Continued From page	2 1	C 022			
	-One staff member, a (PCA) was on dutyResident #1 was starentrance of the facilityResident #6 was sitti entrance of the facilityResident #2 was sitti living room next to Resident #3 was sitti living room watching resident #4 was sitti	y smoking a cigarette. ng in a chair outside at the /. ng in a geriatric chair in the esident #4. ng in a geriatric chair in the television.				
	1. Review of Resident #3's current FL-2 dated 09/15/18 revealed: -Diagnoses of leg swelling/anemia, congestive heart failure, depression, failure to thrive, myocardial infarction, and syncope. -Resident #3 was non-ambulatory -There was documentation Resident #3 was intermittently disoriented. Review of Resident #3's Care Plan dated 2/21/19 revealed: -Resident #3 required extensive assistance from staff with eating, toileting, ambulation, bathing, and transfersResident #3 was totally dependent upon staff for ambulation. Review of Resident #3's Licensed Health Professional Support (LHPS) evaluation dated 03/18/19 revealed the resident's LHPS tasks included assistance with ambulation and mechanical lift transfers. (A Mechanical lift is a device used to transfer individual's by placing a sling under the body and connecting the sling to the mechanical lift).					

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 2 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						С
		FCL078079	B. WING		05	/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE	DRIVE KE, NC 28372			
			TE, NC 20372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 022	Continued From page	2	C 022			
	on 05/29/19 at 10:03 -Resident #3 could not -Resident #3 required staff with bathing, dre -Resident #3 required using a mechanical lift device used to transfer sling under the body at the mechanical lift). Interview with Reside 11:00am revealed: -Resident #3 had liver timeHe liked living at the television.	ot walk. I extensive assistance from ssing, and toileting. I a one-person transfer it. (A mechanical lift is a er individuals by placing a and connecting the sling to on the sling to the sling the sline sline sling the sling the sline				
		ument dated 05/05/18 was appointed a guardian				
	05/29/19 from 9:45am -The resident was tall focused in conversati different off subject co -The resident asked to repeatedlyAt 11:33 am on 05/29 checked out of the fact transferred the resident Interview with Reside 05/30/19 at 9:21 am re-	he same question 0/19 the resident was cility by his guardian who nt via personal vehicle and to the facility on 05/30/19. nt #3's hospice PCA on evealed the hospice PCA				
	transferred Resident and assistance.	#3 with a mechanical lift with				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 3 of 53

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 7P CODE TO CARE DRIVE PEMBROKE, NC 28372 PEMBROKE, NC 28372 PROVIDERS PLAN OF CORRECTION PEMBROKE, NC 28372 PROVIDERS PLAN OF CORRECTION PERSON RECOLATORY OR LSC IDENTIFYING INFORMATION) C 022 Continued From page 3 Interview with Resident #3°s hospice nurse on 0/5/31/19 at 11:02am revealed: -The hospice nurse had worked with the resident quite a bit since being under hospice care. -The patient would need assistance in order to get out of the building in case of an emergency. Interview with a second live-in PCA on 05/31/19 at 10:56 am revealed she used the mechanical lift with no assistance to transfer resident #3°s guardian was unsuccessful on 05/31/19 at 9:05sm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at 10:54". Refer to the review with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the binchrolew with a live-in PCA on 05/31/19 at 2:22pm. Refer to the confidential staff interview. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38 pm.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10 PROVIDER'S SUMMARY STATEMENT OF DEPICIENCISS PREFIX TAG COULD DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COULD DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COULD DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COULD DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COULD DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COULD DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COULD DEPICIENCY MUST BE PRECEDED BY FULL PREFIX TAG COULD DEPICIENCY COULD DEPICE AND COURSE PLAN OF CORRECTION ADVIOURD DEPICE AND COURSE PLAN OF COURSE REFERENCE DEPICE AND COURSE PLAN OF COURS	7.1.12 . 2.1.1			A. BUILDING: _	A. BUILDING:		
DIAL'S FAMILY CARE HOME #10 PREFIX SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY TAG CROSS-HEPERENCED TO THE APPROPRIATE DATE			FCL078079	B. WING		05	
PART	NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	FE, ZIP CODE		
PREFIX TAG ((EACH DEFICIENCY MIST BE PRECEDED BY FILL TAG) (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE PROPRIATE (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE DATE DEFICIENCY) C 022 (Interview with Resident #3's hospice nurse on 05/31/19 at 11:02am revealed: -The hospice nurse had worked with the resident quite a bit since being under hospice careThe patient would need assistance in order to get out of the building in case of an emergency. Interview with a second live-in PCA on 05/31/19 at 10:56 am revealed she used the mechanical lift with no assistance to transfer Resident #3's guardian was unsuccessful on 05/31/19 at 9:05am. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19	DIAL'S FA	MILY CARE HOME #10					
Interview with Resident #3's hospice nurse on 05/31/19 at 11:02am revealed: -The hospice nurse had worked with the resident quite a bit since being under hospice care. -The patient would need assistance in order to get out of the building in case of an emergency. Interview with a second live-in PCA on 05/31/19 at 10:56 am revealed she used the mechanical lift with no assistance to transfer Resident #3. Attempted telephone interview with Resident #3's guardian was unsuccessful on 05/31/19 at 9:05am. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 12/28/18 at 1:30pm. Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54". Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm. Refer to the observations on 05/31/19 from 2:00pm-3:00pm. Refer to the interview with a live-in PCA on 05/31/19 at 2:22pm. Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	COMPLETE
Refer to the telephone interview with	C 022	Interview with Reside 05/31/19 at 11:02am -The hospice nurse he quite a bit since being -The patient would ne get out of the building. Interview with a seconat 10:56 am revealed with no assistance to Attempted telephone guardian was unsucce 9:05am. Refer to the review of Schedule" documentation:30pm. Refer to the interview Manager (BOM) on 0 Refer to the observation:2:00pm-3:00pm. Refer to the interview 05/31/19 at 2:22pm. Refer to the telephone inspector (Assistant Forms) and the seconal se	ent #3's hospice nurse on revealed: ad worked with the resident gunder hospice care. eed assistance in order to g in case of an emergency. Ind live-in PCA on 05/31/19 Ishe used the mechanical lift transfer Resident #3. Interview with Resident #3's ressful on 05/31/19 at If facility's "Fire Rehearsal ation dated 12/28/18 at If with the Business Office 5/30/19 at 5:00pm. It with a live-in PCA on It with a live-in PCA on It with the fire Fire Marshal) on 05/31/19	C 022			

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 4 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _			
		FCL078079	B. WING		C 05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ITE, ZIP CODE	•	
DIAL'S FA	MILY CARE HOME #10	70 CARE [PRIVE			
DIALGIA	WILL CARE HOWE #10	PEMBROK	E, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
C 022	Continued From page	2 4	C 022			
	09/8/18 revealed: -Diagnoses included pulmonary disease (Compose) -There was document intermittently disorientermittently disorientermi	cOPD), prostate cancer, hrenia, and dementia. tation Resident #1 was ted. tation Resident #1 was tation Resident #1 was tation Resident #1 was				
	Interview with Resident #1 on 05/31/19 at 11:08am revealed: -He would get all the residents out of the facility including himself if there was a fireHe had been through a fire drill at the facilityThe staff get the "senior citizens" out of the facility first during a fire drillThe fire alarm sounding meant that there is a fire in the "house".					
	Resident #1 on 05/31 -She visits the resider -It depended on Resident	with a family member of /19 at 10:22am revealed: nt every other day. dent #1's "state of mind" in know to exit the facility				
	(PCP) on 05/30/19 at be concerned that Re	nt #1's primary care provider 5:06pm revealed she would esident #1 would not know nto the building if a fire were				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 5 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
	FCL078079 B. WING			C 05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DIALICEA	MILV CADE HOME #40	70 CARE	DRIVE		
DIAL'S FA	MILY CARE HOME #10	PEMBRO	KE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLETE
C 022	Continued From page	÷ 5	C 022		
		f facility's "Fire Rehearsal ation dated 12/28/18 at			
	Refer to the review of facility's "Fire Rehearsal Schedule" documentation dated 04/15/19 at "10:54".				
	Refer to the interview with the Business Office Manager (BOM) on 05/30/19 at 5:00pm.				
	Refer to the observations on 05/31/19 from 2:00pm-3:00pm.				
	Refer to the interview aide (PCA) on 05/31/	with a live-in personal care 19 at 2:22pm.			
	Refer to the confident	tial staff interview.			
	Refer to the telephone interview with the fire inspector (Assistant Fire Marshal) on 05/31/19 1:38pm.				
	Refer to the interview 05/31/19 at 3:06pm.	with Administrator on			
	03/21/19 revealed: -Diagnoses included osteoarthritis, hyperte	ension, depressive disorder,			
	constantly disoriented	x anxiety. tation Resident #4 was d.			
	semi-ambulatory and ambulate.	tation Resident #4 was used a wheelchair to tation Resident #4 required			

Division of Health Service Regulation

extensive care for bathing and dressing.

STATE FORM 6899 2B5T11 If continuation sheet 6 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLI	EIED
		ECI 079070	B. WING		C 05/31/2019	
		FCL078079			05/3	1/2019
NAME OF PI	ROVIDER OR SUPPLIER		ORESS, CITY, STA	TE, ZIP CODE		
DIAL'S FAMILY CARE HOME #10			ORIVE (E, NC 28372			
040.45	CLIMMADY CT	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	NNI .	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 022	Continued From page	e 6	C 022			
	eating, ambulation, batransfersResident #4 was total toileting and grooming. Observation of Residuat varying times reveauled to the resident ambulation with getting into and of mechanical lift is a desindividuals by placing connecting the sling to the facility in the event wheelchair in her bed resident #4 was dependent #4	s extensive assistance with athing, dressing, and ally dependent upon staff for g. ent #4 on 05/29/19 - 5/31/19 aled: ted in a wheelchair which own. ical lift to assist Resident #4 out of her bed. (A evice used to transfer a sling under the body o the mechanical lift). In personal care aide (PCA) am revealed: mechanical lift for transfers bry but could propel her broom. In personal care aide (PCA) am revealed: mechanical lift for her broom. In personal care aide (PCA) am revealed: It would independently eat seistance. With Resident #4's guardian and revealed: It wo times a month. It is able to get herself out of a fire if she was in her in sident #4 knew what the fire ins, interviews, and record				
	reviews it was determinterviewable.	nined Resident #4 was not				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 7 of 53

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		FCL078079	B. WING		C 05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE	DRIVE KE, NC 28372			
	OLUMANA DV OT		·	DDOV/DEDIO DI ANI GE GODDEGTIO		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CON	(X5) MPLETE DATE
C 022	Continued From page	e 7	C 022			
		facility's "Fire Rehearsal ation dated 12/28/18 at				
		facility's "Fire Rehearsal ation dated 04/15/19 at				
	Refer to the interview Manager (BOM) on 0	with the Business Office 5/30/19 at 5:00pm.				
	Refer to the observations on 05/31/19 from 2:00pm-3:00pm.					
	Refer to the interview 05/31/19 at 2:22pm.	with a live-in PCA on				
	Refer to the confident	tial staff interview.				
		e interview with the fire Fire Marshal) on 05/31/19				
	Refer to the interview with Administrator on 05/31/19 at 3:06pm.					
	10/01/18 revealed: -Diagnoses included	t #6's current FL-2 dated cognitive impairment, tic brain injury and hearing				
	-There was documen ambulatory. -There was documen constantly disoriented	tation Resident #6 was tation Resident #6 was d. tation Resident #6 was very				
	Review of Resident #	6's Care Plan dated				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 8 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
		FCL078079	B. WING		05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE				
			KE, NC 28372		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
C 022	Continued From page	e 8	C 022			
	09/28/18 revealed: -Resident #6 was inditioleting, ambulation/light dressing, grooming/putransferringResident #6 was recomental illness. Interview with Reside revealed: -If there was a fire in the form a fire extinguisherHe would get everyously would be "up to" him of the facilityHe would tell the word had not been through the facilityHe had not been through the facilityInterview with a live-iron 05/30/19 at 3:12pr "short term memory to be some of a fireThe guardian was unknow when it was safter to the review of Schedule" documentation. Refer to the review of Schedule" documentation.	ependent with eating, occomotion, bathing, ersonal care hygiene, and eiving medications for nt #6 on 5/31/19 at 11:02am the facility he would first look ne out of the facility. In the get all the residents out of the fire. Sough a fire drill at the facility. In personal care aide (PCA) on revealed Resident #6 had				
	Refer to the interview	with the Business Office 5/30/19 at 5:00pm				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 9 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL078079	B. WING		05	C 5/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10		E DRIVE			
0/10/15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	OKE, NC 28372	PROVIDER'S PLAN OF CO	APPECTION .	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
C 022	Continued From page	e 9	C 022			
	Refer to the observat 2:00pm-3:00pm.	ions on 05/31/19 from				
	Refer to the interview 05/31/19 at 2:22pm	with a live-in PCA on				
	Refer to the confident	tial staff interview.				
		e interview with the fire Fire Marshal) on 05/31/19				
	Refer to the interview 05/31/19 at 3:06pm.	with Administrator on				
	03/07/19 revealed: -Diagnoses included dementia, anemia, gavein thrombosis, hypeinsulin dependent diagastroesphogeal reflutureThere was documen constantly disorientedThere was documen total care for personal Review of Resident # 03/07/19 revealed the resident required external	astrointestinal bleed, deep ertension, atrial fibrillation, betes mellitus, gastritis and ux disease. tation the resident was d. tation the resident required al care assistance from staff.				
	on 05/29/19 at 10:03a used a mechanical lif to ambulate and was for all of her needs. (a used to transfer indivi	ferring. n personal care aide (PCA) am revealed Resident #2 t for transfers, was not able totally dependent on staff A mechanical lift is a device iduals by placing a sling onnecting the sling to the				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 10 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		FCL078079	B. WING		05/3	1/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE				
040.45	CLIMMADV CT.		KE, NC 28372	DDOVIDED'S DI ANI OF CORDECTION		0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 022	Continued From page	2 10	C 022			
	to get her out of the fa-If a fire occurred while she would drag the best on it out of the facility "heavy". Based on observation review, it was determined interviewable. Refer to the review of Schedule" documentation. Refer to the review of Schedule documentation. Refer to the interview Manager (BOM) on other to the observation. Refer to the interview of Schedule documentation. Refer to the observation. Refer to the interview of Schedule documentation. Refer to the observation. Refer to the interview of Schedule documentation. Refer to the observation. Refer to the interview of Schedule documentation. Refer to the observation. Refer to the confident documentation.	evealed: impletely dependent on staff acility in the event of a fire. He Resident #2 was in bed, ed mattress with the resident but Resident #2 was ins, interviews, and record ined Resident #2 was not if facility's "Fire Rehearsal ation dated 12/28/18 at if facility's "Fire Rehearsal ation dated 04/15/19 at with the Business Office 5/30/19 at 5:00pm. ions on 05/31/19 from				
	Refer to the interview 05/31/19 at 3:06pm.	with Administrator on				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 11 of 53

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		FCL078079	B. WING		C 05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE [PRIVE			
PEMBRO		PEMBROK	E, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
C 022	Continued From page	e 11	C 022			
	Review of facility's "F documentation dated revealed: -Staff included a live-and the Business Offi -The total time for all facility was 5 minutes -The fire drill was con -The live-in PCA "pus then Resident #4 while everyone else to go of live-in PCA got Resid Review of facility's "F documentation dated revealed: -Staff included a live-The total time for all facility was 9 minutes -The residents were in drillThe live-in PCA told	ire Rehearsal Schedule" 12/28/18 at 1:30pm in personal care aide (PCA) ice Manager (BOM). residents to evacuate the . inpleted at 1:35pm. shed out Resident #2 first, le the live-in PCA was telling out the front door, then the ent #3 out of the "house". ire Rehearsal Schedule" 04/15/19 at "10:54" in PCA and the BOM. residents to evacuate the . in the living room during the the residents to evacuate. ' the three non-ambulatory				
	Interview with the BOM on 05/30/19 at 5:00pm revealed: -She was responsible for performing unannounced fire drills for the facility every 3					
	and observed the rea resident reactions and evacuate the resident -Staff had been trained	she pulled the fire alarm ctions of the live-in PCAs, d timed how long it took to ts. ed in the event of a fire to residents at an exit away				
	from the fireIf Resident #2 was in had been instructed to	n the bed, the live-in PCAs o always get her out first two residents (Resident #3				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 12 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL078079	B. WING		C 05/31/2019
	ROVIDER OR SUPPLIER	70 CARE	DDRESS, CITY, STA DRIVE DKE, NC 28372	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 022	and Resident #4)Staff had been instruresident that was loca- Staff had been instrue #1, Resident #5 and F fire and to get out of too the resident #1, Resident exit the building without the facility was grouf front door, a wheelch too the facility was grouf for the facility was grouf the facility was grouf the facility with a live-inguity with a live-inguity with a live-inguity in time if there the only staff person inguity in time if there the only staff person inguity in the facility were out the facility would be professed to the facility would still have the facility was not still the facility was	cted to always evacuate the sted closet to the fire. Cted to "holler" at Resident Resident #6 that there was a she building. In the step and Resident #6 could ut any other prompting. 1/19 from 2:00pm-3:00pm Equipped with a sprinkler and level with no steps at the eair ramp at both exit doors cility, and an exit door in the step that led to concrete at an PCA on 05/31/19 at ared to death" that she would be step that led to concrete at an existence of the was a fire because she was in the house. Decause she would be a non-ambulatory residents are other 3 residents residing a safely. In existence of the staff in the facility if there was a residents were completely exit the facility and then on make sure the other responded to the fire alarm.	C 022		

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 13 of 53

Division of Health Service Regulation

Division	of Health Service Regu	lation				
STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D. WING		С	
		FCL078079	B. WING		05/3	31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE ZIP CODE		
			, ,			
DIAL'S FA	MILY CARE HOME #10	70 CARE				
		PEMBRO	KE, NC 28372			1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT OR I	LOC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/112
				,		
C 022	Continued From page	e 13	C 022			
	(Assistant Fire Marsh	al) on 05/31/19 1:38pm				
	revealed:	ai, en ee, en re 1.eepin				
		oncern with one staff person				
		bulatory residents out of the				
	facility timely in the ev	-				
		uld have to physically move				
		resident out which would				
	take time.					
		one staff person could				
		ulatory residents out of the				
		of the other residents had				
	•	the event of an active fire.				
		orinkler system it would				
		enario and give one-person				
	time to get each resid					
	anno to got odon room	ioni out of the identy.				
	Interview with the Adr	ministrator on 05/31/19 at				
	3:06pm revealed:					
		ave a sprinkler system.				
		have a sprinkler system.				
		were staff within close				
		ome to help the one staff				
		to get residents out of the				
	facility in the event the					
		here was never a fire in the				
	facility.					
	•	er ambulatory residents				
	_	could evacuate the facility in				
		ependently without any staff				
	assistance.					
	-She was licensed for	3 nonambulatory residents				
	but was not aware re					
		ounted" as nonambulatory				
	residents in the event					
	evacuation.	· ,				
	The facility failed to a	ssure the building was				
		ined to allow the residents				
		no had physical and cognitive				
	deficits to evacuate in	ndependently in case of an				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 14 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					c	
		FCL078079	B. WING		05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
TO WILL OF TH	TO VIDER OR OUT FEET	70 CARE D		12, 211 0002		
DIAL'S FA	MILY CARE HOME #10		E, NC 28372			
<u>-</u>	CLIMMADV CT		1		1 0.00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 022	Continued From page	e 14	C 022			
	emergency such as a fire. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.					
		vas submitted by the facility .S. 131D-34 on 05/31/19.				
	CORRECTION DATE VIOLATION SHALL N 2019	FOR THE TYPE B OT EXCEED JULY 15,				
C 191	10A NCAC 13G .060 ² Staff	1(d) Management and Other	C 191			
	Staff	1 Management and Other				
	for housekeeping and the residents.	I the supervision and care of				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa on duty and awake at personal care and sup	ns, interviews, and record iled to have sufficient staff all times to meet the pervision needs for 4 of 6 esident #1, #2, #3, #4 and				
	The findings are:					

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 15 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND I DAN OF CONNECTION		A. BUILDING: _		COMPLETED		
			B. WING		С	
		FCL078079	B. WING		05/31/2019	_
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE D				
	I		E, NC 28372			\dashv
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF THE APPROPRIED CONTROL OF T	BE COMPLETE	:
C 191	Continued From page	e 15	C 191			
		ensus revealed 6 residents				
		n/19 at 9:45am revealed one n personal care aide (PCA)				
	Interview with a live-in PCA on 05/29/19 at 10:03am revealed: -She was the only staff currently present on dutyShe worked 48 hour shifts that started on Mondays at 2:00pm through Wednesday at 2:00pm, then reported back to work on Friday at 2:00pm and worked until Monday at 2:00pmShe slept at night from 10:00pm to 6:00am in the live-in quarters of the facility.					
	A second interview with the live-in PCA on 05/29/19 at 11:46am revealed: -The facility had an audible call alarm system that was activated when the residents pulled a "pullstring" that was located at the residents' bedside. -The call system's main unit hub was located in the live-in's sleeping quarters. -When the call system was activated by a resident an audible alarm was activated and an indicator light illuminated.					
	03/07/19 revealed: -Diagnoses included a dementia, anemia, ga vein thrombosis, hype insulin dependent dia gastroesphogeal reflu-There was document constantly disoriented -There was document	astrointestinal bleed, deep ertension, atrial fibrillation, betes mellitus, gastritis and ux disease. tation the resident was				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 16 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С
FCL078079		B. WING		05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
DIAL'S FA	MILY CARE HOME #10	70 CARE I	DRIVE		
DIALOTA	WILL CARE HOME #10	PEMBRO	(E, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 191	Continued From page	e 16	C 191		
	Review of Resident #2's Care Plan dated 03/07/19 revealed there was documentation the resident required extensive assistance from staff for mobility and transferring.				
	on 05/29/19 at 10:03a 2:25pm revealed:	n personal care aide (PCA) am and on 05/31/19 at mechanical lift for transfers,			
	was not able to ambu dependent upon staff mechanical lift is a de	late and was totally for all of her needs. (A vice used to transfer			
	connecting the sling to -Resident #2 could no	ot activate the call system for			
	-She thought Resider	w how or when to pull the			
	-Before she went to s made the sure the cal	leep at night she always Il system pull string was not In because she was afraid			
	the resident would ge				
	Interview with a second live-in PCA on 05/30/19 at 3:12pm revealed Resident #2 was not physically or mentally able to call for help using the call system but when she heard her make any noises she would get up and check on her.				
	Telephone interview with Resident #2's family member on 05/31/19 at 4:40pm revealed: -Resident #2 had dementia and was completely dependent on staff for all of her needsShe was aware staff slept in the facility at night.				
		with Resident #2's primary on 05/30/19 at 5:22pm			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 17 of 53

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY LETED
			755.2516.			С
		FCL078079	B. WING			31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S EA	MILY CARE HOME #10	70 CARE	DRIVE			
DIAL 3 FA	INILIT CARE HOWE #10	PEMBRO	KE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
C 191	Continued From page	: 17	C 191			
C 191	-Resident #2 should he supervision and would the facility at all times -The PCP was unawa 24-hour staffShe had safety concresidents could not conclude the expected staff to the care of the resider. She expected staff to the care of the resider interview with the Adra 3:19pm revealed she having awake staff from supervise Resident #3. Based on interviews, determined Resident Refer to the interview ob/29/19 at 10:03am Refer to the interview on 05/30/19 at 3:12pm. Refer to the interview of Salary at 3:19pm. Refer to the interview of Salary at 3:19pm.	nave 24-hour care and dexpect staff to be awake in are the facility had no awake erns because some of the communicate the need for not needed it. To be awake at all times for nots. ministrator on 05/31/19 at had no concerns with not come 10:00pm to 6:00am to 2. and record review, it was #2 was not interviewable. with a live-in PCA on and on 05/31/19 at 2:25pm. with a second live-in PCA m. with the Administrator on and #4's current FL-2 dated mental retardation, ension, depressive disorder, it hyperlipidemia,	C 191			
	ambulatory with a whe-The was documental constantly disoriented Review of Resident #	tion the resident was I.				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 18 of 53

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		FCL078079	B. WING		C 05/31/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	1 00.0 20.10
NAME OF T	NOVIDEN ON 3011 EIEN	70 CARE		11, 211 GODE	
DIAL'S FA	MILY CARE HOME #10		KE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 191	Continued From page	= 18	C 191		
	revealed an admissio	n date of 12/17/2003.			
		cument revealed Resident ncompetent and appointed a			
	on 05/29/19 at 10:03a 2:25pm revealed:	n personal care aide (PCA) am and on 05/31/19 at			
	-Resident #4 used a i was not able to ambu dependent on staff fo	•			
	mechanical lift is a de	•			
		a sling under the body and			
	connecting the sling t	•			
		ot tell staff what she needed.			
	-Resident #4 was cor	ntused at night. ot activate the call system			
	when she was in her				
	-She thought Resider				
	_	w how or when to pull the			
	_	leep at night she always			
	made the sure the ca	ll system pull string was not			
		h because she was afraid			
	the resident would ge	t tangled in the cord.			
	Interview with a seconat 3:12pm revealed R	nd live-in PCA on 05/30/19			
	-	I for help using the call			
		heard her make any noises			
	she would get up and				
		with Resident #4's primary on 05/30/19 at 5:22pm			
		nave 24-hour care and			
	-	d expect staff to be awake in			
	the facility at all times				
	│-The PCP was unawa	are the facility had no awake			

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 19 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. 55125/NO.		С	
		FCL078079	B. WING		05/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE				
		PEMBRO	KE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE COMPLETE	
C 191	Continued From page	e 19	C 191			
	residents could not co	b be awake at all times for				
	Interview with the Administrator on 05/31/19 at 3:19pm revealed she had no concerns with not having awake staff from 10:00pm to 6:00am to supervise Resident #4.					
		and record review, it was #4 was not interviewable.				
		with a live-in PCA on and on 05/31/19 at 2:25pm.				
	Refer to the interview on 05/30/19 at 3:12pr	with a second live-in PCA m.				
	Refer to the interview 05/31/19 at 3:19pm.	with the Administrator on				
	3. Review of Resident #3's current FL-2 dated 09/15/18 revealed: -Diagnoses included leg swelling/anemia, congestive heart failure, depression, failure to thrive, myocardial infarction, and syncopeThere was documentation Resident #3 was non-ambulatory -There was documentation Resident #3 was intermittently disoriented.					
	on 05/29/19 at 10:03a 2:22pm revealed: -Resident #3 could no	iters of oxygen at night.				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 20 of 53

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING:			
		FCL078079	B. WING		05/31	/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE I	ORIVE (E, NC 28372			
0/0.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTIO	MI.	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 191	Continued From page	e 20	C 191			
	throughout the nightResident #3 did not I nightResident #3 required staff with bathing, dre-Resident #3 required using a mechanical lift is a device used to tra a sling under the body the mechanical lift)She told Resident #3 oxygen in his nose ar oxygen in his nose the she got up at night. Interview with a second 3:12pm revealed at control pull his call string	ike to wear his oxygen at d extensive assistance from essing, and toileting. d a one-person transfer ft transfer (A mechanical lift ansfer individuals by placing y and connecting the sling to d every night to keep his nd the resident had his e "majority of the time" when and live-in PCA 05/30/19 at one time Resident #3 would to alert staff for help but				
	his call string cord in Observations of Residual	dent #3 intermittently on				
	05/29/19 from 9:45am - 11:33am revealed: -The resident was talkative but could not stay focused in conversation and would divert to different off subject conversationsThe resident asked the same question repeatedly.					
	Review of court docurrevealed Resident #3 of the person.	ment dated 05/05/18 was appointed a guardian				
	11:02am revealed: -The hospice nurse h quite a bit since being -Resident #3 was ord night that treated mul	ered to wear his oxygen at				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 21 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
FCL078079 B. WING			05	C 5/31/2019		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
DIAL'S FA	AMILY CARE HOME #10	70 CARE PEMBRO	E DRIVE DKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 191	his nasal cannula war-Oxygen would help in nightSupplemental oxyge #3's oxygen saturation sleeping and lying flateresident #4's oxyge range when checked. Telephone interview was care provider (PCP) or revealed: -Resident #3 should it is supervision and would the facility at all times. The PCP was unaward 24-hour staffShe had safety concresidents could not conclude the care of the resider. She expected staff to the care of the resider interview with the Add 3:19pm revealed she having awake staff for supervise Residents. Attempted telephone guardian was unsucced 9:05am. Refer to the interview of 5/29/19 at 10:03am. Refer to the interview on 05/30/19 at 3:12pm.	s worn at night. Resident #3 rest better at n would help keep Resident ns up at night when he was t in the bed. n levels had been in normal with Resident #3's primary on 05/30/19 at 5:22pm have 24-hour care and d expect staff to be awake in are the facility had no awake erns because some of the ommunicate the need for nt needed it. b be awake at all times for nts. ministrator on 05/31/19 at had no concerns with not om 10:00pm to 6:00am to #3. interview with Resident #3's essful on 05/31/19 at with a live-in PCA on and on 05/31/19 at 2:25pm.	C 191			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 22 of 53

FCL078079 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	C 05/31/2019
1 3 2 3 7 6 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	05/31/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
DIAL'S FAMILY CARE HOME #10	
PEMBROKE, NC 28372	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE IENCY)
C 191 Continued From page 22 C 191	
4. Review of Resident #6's current FL-2 dated 10/01/18 revealed: -Diagnoses included cognitive impairment, hypertension, traumatic brain injury and hearing deficitThere was documentation the resident #6 was ambulatory, constantly disoriented and was very hard of hearing. Review of Resident #6's Care Plan dated 09/28/18 revealed: -Resident #6 was independent with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal care hygiene, and transferringResident #6 was receiving medications for mental illness. Interview with Resident #6 on 05/29/19 at 11:12am revealed: -He was very hard of hearing and could not hear anything out of his right earHe did not sleep well at night and had spoken with his primary care provider (PCP) about thatHe had a past history of a head injury, "I don't have a brain that works right". A second interview with Resident #6 on 05/31/19 at 11:02am revealed: -He had seen a string in his room (call string) but did not know what it was forWhen he got up at night he didn't need anything from staff and stayed in his room. Interview with a second live-in personal care aide (PCA) on 05/30/19 at 3:12pm revealed: -Resident #6 had told her he was not sleeping at night and when she did get up at night to check	

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 23 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		_				
		FCL078079	B. WING			1/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE D				
()(1)	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	E, NC 28372	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 191	Continued From page	e 23	C 191			
	did not come out of hi-Resident #6 shared a #4She always locked R night to keep Resider Resident #4's room b Resident #6 that well the facility a short tim-She never saw Resideatlity at night except bathroom when she gresidentsResident #6 had "ag she was not aware of agitation with other re-Resident #6 would p loud if staff told him a to be done and it was	ort term memory loss" but is room at night. a bathroom with Resident Resident #4's bathroom at nt #6 from entering into ecause she did not know since he had only lived at e. dent #6 anywhere in the this bedroom or his got up to check on the itation" at times with staff but Resident #6 having esidents. ace and become verbally specific time for something to done at the specific time he did become agitated when he				
	Telephone interview with Resident #6's primary care provider (PCP) on 05/30/19 at 5:22pm revealed: -The PCP was unaware the facility had no awake 24-hour staffShe expected staff to be awake at all times for the care and supervision of the residents but was not concerned for the ambulatory residents needing staff assistance in the facility at night.					
	05/29/19 at 10:03am	with a live-in PCA on and on 05/31/19 at 2:25pm.				
	on 05/30/19 at 3:12pr	with a second live-in PCA n.				

Division of Health Service Regulation

Refer to the interview with Administrator on

STATE FORM 8899 2B5T11 If continuation sheet 24 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		FCL078079	B. WING		05/3	1/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ITE, ZIP CODE	•	
DIAL'S EA	MILY CARE HOME #10	70 CARE I	DRIVE			
DIAL 3 FA	IMILIT CARE HOME #10	PEMBRO	KE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
C 191	Continued From page	e 24	C 191			
	05/31/19 at 3:19pm.					
	09/8/18 revealed: -Diagnoses included opulmonary disease (Cotobacco use, schizopi-There was documen intermittently disorien Review of Resident #10/19/18 revealed: -Resident #1 required staff with bathing, dreindependent with eatitransferring, and super-Resident #1 was recomedication. Interview with Reside 11:08am revealed he	cOPD), prostate cancer, hrenia, and dementia. tation Resident #1 was ted and was ambulatory. T's Care Plan dated Ilimited assistance from essing, and grooming, was ng, ambulation, and ervision with toileting. eiving mental health				
	on 05/30/19 at 3:12pr	n personal care aide (PCA) m revealed: wander inside the facility or				
	try to go outside at nig were activated.	ght after the door alarms				
	-Resident #1 did not i	need staff assistance at				
	independently.					
	care provider (PCP) of a care provider (PCP) of a care and supervised and care and supervised are care ar	with Resident #1's primary on 05/30/19 revealed: are the facility had no awake of be awake at all times for sion of the residents but was ambulatory residents				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 25 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL078079	B. WING		05	C 5/ 31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	, ,	
DIAL IS EA	MILV CARE HOME #40	70 CARE	DRIVE			
DIAL 5 FA	MILY CARE HOME #10	PEMBRO	OKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 191	Continued From page	25	C 191			
	needing staff assistar	nce in the facility at night.				
		with a live-in PCA on and on 05/31/19 at 2:25pm.				
	Refer to the interview on 05/30/19 at 3:12pr	with a second live-in PCA n.				
	Refer to the interview 05/31/19 at 3:19pm.	with Administrator on				
	Interview with a live-in personal care aide (PCA) on 05/29/19 at 10:03am and on 05/31/19 at 2:25pm -She was a "light sleeper" and did not sleep all nightShe always slept with her door opened at nightShe would get up if she heard a "cough or something" but sometimes she did not get up at all to check on the residents.					
	at 3:12pm revealed: -She did not sleep we at least twice during t residentsShe typically activate	ell at night and always got up the night to check on the ed the door alarms around around 10:00pm and got up ext morning.				
	3:19pm revealed she were required 24 hou	ministrator on 05/31/19 at was not aware awake staff rs a day for the supervision sical or cognitive limitations,				
	awake at all times to personal care needs	ave awake staff on duty and meet the supervision and for 4 of 6 sampled residents ently and/or disoriented. The				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 26 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL078079	B. WING		05	C 5/ 31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
DIAL'S FA	AMILY CARE HOME #10		E DRIVE OKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
C 191	and welfare of the re- Type B Violation. A Plan of Protection in accordance with G	letrimental to health, safety, sidents and constitutes a was submitted by the facility i.S. 131D-34 on 05/31/19.	C 191			
C 246	to meet the routine a of residents. This Rule is not met TYPE B VIOLATION Based on observatio reviews, the facility fa follow-up with the pri sampled residents re	2 Health Care assure referral and follow-up nd acute health care needs	C 246			
	3/21/19 revealed: -Diagnoses included osteoarthritis, hypertother and unspecified esophagitis, and refle-There was documer semi ambulatory with	ension, depressive disorder, d hyperlipidemia, ex anxiety. ntation that the resident was				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 27 of 53

FCL078079 B. WING 05.	C 31/2019
FCL078079 B. WING 05.	_
NAME OF PROVIDED OR GURDUED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
70 CARE DRIVE	
DIAL'S FAMILY CARE HOME #10 PEMBROKE, NC 28372	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 246 Continued From page 27 constantly disorientedThere was an order for no added salt diet. Review of Resident #4's resident register revealed an admission date of 12/17/03. Review of a court document revealed Resident #4 was adjudicated incompetent and appointed a guardian of the person on 06/12/18. Review of Resident #4's Care Plan dated 12/11/18 revealed the resident requires extensive assistance with eating. Observation Resident #4's lunch meal on 5/29/19 from 12:30 - 12:45pm revealed: -The resident fed herselfThe resident coughed constantly while eatingThe resident made a constant gurgling sound while eating The resident fed herself The resident fed herself Resident #4's dinner meal on 5/29/19 at 5:00pm - 5:15pm revealed: - The resident fed herself Resident #4 begun coughing after her first bite of food Resident #4 made a constantly while eating Resident #4 made a constantly while eating Resident #4 gagged while eating The live-in PCA was providing feeding assistance to another resident The live-in PCA asked Resident #4 had trouble swallowing her food The live-in PCA asked Resident #4 fis he was	

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 28 of 53

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					c	;
FCL078079		B. WING		1	1/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE				
			KE, NC 28372		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 246	Continued From page	28	C 246			
	her beverage when co	oughing.				
	9:20am revealed: -She had noticed Resswallowing last weekShe felt that Residentest"Resident #4 "chewed the food down with heable to swallow it noneShe had noticed Resher food as she used swallowingShe had not reported issue to anyoneShe did not document concerns because sher concernsTypically, she notified aide/supervisor in chaduring his medication.	at #4 needed a "swallowing It her food she then pushed It tongue instead of being It mally". It ident #4 no longer ate all It too due to trouble It Resident #4's swallowing Int any of her observations or It is did not have a notebook. In in place of documenting It is did not have a notebook. In in place of documenting It is did not have a notebook.				
	Interview with the MA/SIC on 5/31/19 at 4:02pm revealed: -He had not noticed Resident #4 having trouble swallowingThe live-in staff had not made him awareHad he known of the swallowing difficulty he would have made Resident #4's primary care provider (PCP) aware.					
	3:46pm revealed:	ministrator on 5/30/19 at				

Division of Health Service Regulation

-She or MA/SIC would talk with Resident #4's

STATE FORM 8899 2B5T11 If continuation sheet 29 of 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, ,	E SURVEY PLETED	
		FCL078079	B. WING		05	C 5/ 31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
514116 54		70 CARE	DRIVE			
DIAL'S FA	MILY CARE HOME #10	PEMBRO	OKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
C 246	PCP had she been m -She would ask staff t until the PCP address -She expected the live management staff aw trouble swallowing wh of reportingThe MA/SIC was res referral and follow-up Review of a diet orde PCP on 5/30/19 for R order for chopped foo Observation of Reside 5/31/19 at 8:03am rev -Resident 4's breakfa -Resident had trouble -The live-in PCA aske "alright"The live-in PCA enco her beverage. Interview with Reside 5:06pm revealed: -No one made her aw trouble swallowing for -She expected the fact Resident #4 had troul they noticed the proble -She would order a m for further evaluation. Based on observation	ade aware. To chop Resident #4's food Seed the swallowing concern. Se-in PCA to make Fare that Resident #4 had Sich was the normal process ponsible for healthcare incidences. It signed by Resident #4's sesident #4 revealed a diet sids. Sent #4's breakfast meal on sealed: Set meal was chopped. Se swallowing her food. Set Resident #4 if she was souraged Resident #4 to drink Sent #4's PCP 5/30/19 at sere that Resident #4 had sea a week. Sellity to make her aware that sole swallowing as soon as seem or change. Sodified barium swallow test	C 246	DEFICIENCY		
	The facility failed to n care provider of the red difficulties during mea					

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 30 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING		C
		FCL078079	B. WING		05/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
DIAL'S FA	MILY CARE HOME #10	70 CARE			
	OLIMANA DV. OT		KE, NC 28372	DDOWDEDIO DI AN OF CODDECTIO	<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 246	Continued From page	30	C 246		
	resident's swallowing detrimental to the hea	o her ordered diet and sting to assess and treat the difficulties. This failure was alth, welfare and safety of nstitutes a Type B Violation.			
		vas submitted by the facility S. 131D - 34 on 5/31/19.			
	CORRECTION DATE VIOLATION SHALL N 2019.	FOR THE TYPE B IOT EXCEED JULY 15,			
C 284	10A NCAC 13G .0904 Service	4(e)(4) Nutrition and Food	C 284		
	(4) All therapeutic die supplements and thic	Nutrition and Food in Family Care Homes: ets, including nutritional kened liquids, shall be the resident's physician.			
	This Rule is not met a	as evidenced by:			
	reviews, the facility fa diets were served as resident who was diag	ns, interviews and record iled to assure therapeutic ordered for 1 of 1 sampled gnosed with advanced order for a pureed diet			
	The findings are:				
	Review of Resident #. 03/07/19 revealed:	2's current FL-2 dated			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 31 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		FCL078079	B. WING		C 05/31/2019
NAME OF D	ROVIDER OR SUPPLIER		DDESS CITY STA	TE ZID CODE	1 00/01/2013
NAME OF P	ROVIDER OR SUPPLIER	70 CARE	DRESS, CITY, STA DRIVE	ILE, ZIP CODE	
DIAL'S FA	MILY CARE HOME #10		KE, NC 28372		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
C 284	Continued From page	e 31	C 284		
0 204	-Diagnoses included dementia, anemia, gavein thrombosis, hypeinsulin dependent dia gastroesophageal ref-There was an order (NCS) pureed dietThere was documen constantly disoriented There was documen "total care" for persor staff. Review of Resident # Plan dated 03/07/19 in the care of the	Alzheimer's disease, astrointestinal bleed, deep ertension, atrial fibrillation, betes mellitus, gastritis and lux disease. For a no concentrated sweet tation the resident was d. tation the resident required hal care assistance from 2's Assessment and Care revealed:			
	always disoriented ar	tation the resident was ad had a significant memory action. tation the resident required			
		from staff with eating.			
	refrigerator in the faci	s diet list posted on the lity's kitchen on 05/29/19 at esident #2 was on a NCS,			
	on 05/29/19 at 12:06p -She made sure Resi into "smaller pieces" a for "years"She thought Resider one time because the -She was aware the f kitchen indicated that order was for a puree dietShe was told by the	n personal care aide (PCA) om revealed: dent #2's foods were cut and she had been doing that at #2 was on a pureed diet at a resident could not swallow. acility's diet list posted in the Resident #2's current diet ad, no concentrated sweet Business Office Manager #2's food did not have to be			
		ted" to puree the resident's			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 32 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		B WING		С		
		FCL078079	B. WING		05/31/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S EA	MILY CARE HOME #10	70 CARE	DRIVE			
DIALGIA	IMILI CARL HOML #10	PEMBRO	KE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 284	Continued From page	e 32	C 284			
	foods. -She usually did not p	ouree Resident #2's foods would not eat it and would				
	on 5/29/19 at 12:07pr -Resident #2's food w	as prepared by the live-in				
	personal care aide (P -Resident #2's food w	vas not pureed.				
	-Resident #2 was served turkey, gravy, bow tie noodles, mashed potatoes, green beans, roll and mandarin orangesThe live-in PCA sat beside Resident #2 and					
	assisted the resident					
	spoon and fed Reside	e placing the food on the ent #2 the foods cut into				
		novements with her bottom				
	jaw then swallowed the observed difficultyResident #2 ate 100	•				
	Observation of a second at 4:27pm revealed:	ond live-in PCA on 05/29/19				
	that was broken into	placed a cooked hamburger pieces, bread and water in a				
		he blender running to puree ssembled the food on plates				
	for the other residents. -The live-in PCA stopped the blender and stirred					
	to the food and starte	nore water and mayonnaise d the blender again to puree				
	the food. -After approximately 2 stopped the blender a hamburger, bread and -The food was in a pu	d mayonnaise.				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 33 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
						С
		FCL078079	B. WING		0.5	5/31/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIR CODE	•	
NAME OF I	NOVIDEN ON 3011 EIEN	70 CARE		, ZII GODE		
DIAL'S FA	MILY CARE HOME #10		OKE, NC 28372			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
C 284	Continued From page	e 33	C 284			
	water in the blender a intervals and would s canister and restart the in a mashed potato or pureed French fries a through the French fr Observation of Residemeal on 5/29/19 at 5:	ent #2 during the dinner				
	with mayonnaise, Fre -The second live-in P and assisted the resid	ench fries, and apple sauce. CA sat beside Resident #2				
	at 5:30pm revealed: -Resident #2 was on -She always pureed a before serving and fe -She thought it was ir in a "smooth", "puddin chunks" of food, so th the foods easilyShe had received tra years ago (unable to had to demonstrate to foodsShe knew what orde	all of Resident #2's foods eding the resident. nportant for the foods to be ng like" consistency with "no ne resident could swallow nining from "a lady" a few recall the exact time) and to the "lady" how to puree red diet each resident was				
	but the BOM was res residents' diet order of -She occasionally wo canister to make sure side of the canister an	of the residents' diet orders ponsible for updating the on to the posted diet list. uld shake the blender's a the foods were not on the not to make sure the foods with the blades to remove				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 34 of 53

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING:		COMPLETED	
		FCL078079	B. WING		05/31/2019	
			1			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		70 CARE I	DRIVE			
DIAL'S FA	MILY CARE HOME #10	PEMBRO	E, NC 28372			
			12, 110 20012			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		_
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		-
TAG	REGULATORT OR L	30 IDENTIFTING INFORMATION)	TAG	DEFICIENCY)	IAIE BAIE	
				,		-
C 284	Continued From page	34	C 284			
	any food chunks and	pieces.				
	Telephone interview v	vith Resident #2's guardian				
	on 05/31/19 at 4:40pr					
		ered a stroke and since				
		ureed diet and her speech				
	was also effected by t					
	_					
		e live-in PCAs (named as				
	_	as observed on 05/29/19				
	-	r meal for Resident #2) who				
	was "a little more afra					
	Resident #2 with eatir	ng than the other live-in PCA				
	that worked in the fac	ility.				
	-She had visited wher	n the other live-in PCA did				
	not puree Resident #2	2's food and chopped "the				
	-	of serving the food to the				
	resident in a pureed of					
	=	t observed Resident #2				
	· ·					
		wallowing food that was not				
		cy, no observations of the				
	resident coughing dur	ring a meal.				
	Interview with the BO	M on 05/30/19 at 5:00pm				
	revealed:					
	-She was responsible	for updating the diet list for				
	-	ved the latest diet ordered				
	•	ary care provider (PCP).				
	-	re responsible for preparing				
		according to the diet list.				
		ed the live-in PCAs not to				
	puree Resident #2's f					
		for Resident #2 to have her				
		esident would not choke.				
		y monitor the meals served				
	to the residents unles	s she was in the facility				ļ
	during the residents' r	neals.				ļ
		d staff serving foods that				
	were not pureed.	J				

Division of Health Service Regulation

A second interview with the live-in PCA that

STATE FORM 8899 2B5T11 If continuation sheet 35 of 53

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	1 .		COMPLI	ETED
					_ ا	
		FCL078079	B. WING		05/3	1/2019
			1		1 03/3	1/2019
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE I				
		PEMBRON	E, NC 28372			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
C 284	Continued From page	35	C 284			
	. •					
		ood on 05/29/19 that was not				
	pureed on 05/31/19 a					
		at anything and ate better				
		ee the resident's food.				
	that she thought woul	Resident #2 anything to eat				
	•	hat a PCP's order was				
		dent #2's a chopped diet				
	instead of a pureed d					
		oughed, choked or seemed				
		when eating chopped food.				
	-The Administrator, m	edication aide/supervisor-in				
	-charge (MA/SIC) and	the BOM did not monitor				
	the residents' meals of	or the preparation of the				
		s they just "pop in" when she				
	was preparing or serv	ring the residents' meals.				
	Intonious with the MA	/SIC on E/21/10 at 1:06pm				
	revealed:	/SIC on 5/31/19 at 4:06pm				
		lity of the office staff which				
	-	rator and BOM to ensure				
		g followed as ordered.				
		at Resident #2's meals were				
	not always being serv					
	-The live-in staff were	aware that they were				
	supposed to puree Re	esident #2's foods.				
		ns, interviews, and record				
		nined Resident #2 was not				
	interviewable.					
	Interview with the Adr	ministrator on 5/31/19 at				
	3:06pm revealed:					
	•	nstruction concerning				
	pureed diets.	9				
	-Puree was the easies	st diet order to follow.				
	-There was no training	g provided to staff on the				
	preparation of therape	- -				
		e diet orders in the kitchen				
	for live-in PCAs to foll	low.				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 36 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 20.22.1.10.		С
		FCL078079	B. WING		05/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
514116 54		70 CARE	DRIVE	,	
DIAL'S FA	MILY CARE HOME #10	PEMBRO	KE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 284		: 36 et order changed it was st, posted in the kitchen and	C 284		
	administrative staffShe was not aware the	n staff by the BOM and			
		t #2's therapeutic diet order. that Resident #2's food be by the diet order.			
	05/30/19 at 5:22pm re	vith Resident #2's PCP on evealed: ced on a pureed diet for			
	aspiration precautions Alzheimer's disease.	because of advanced (Aspiration is when foods or ns airway which could lead			
	to trouble breathing, lu	ung infections and n precautions are practices nt foods or fluids from			
	, .	follow the residents' diet			
	served as ordered for ordered to receive put	ssure therapeutic diets were Resident #2 who was reed foods for aspiration observed receiving chopped			
	foods during a meal o failure to assure Resid foods was detrimenta	bservation. The facility's dent #2 received pureed I to the health and safety of			
		enstitutes a Type B Violation.			
	in accordance with G.	vas submitted by the facility S. 131D-34 on 05/30/19.			
	CORRECTION DATE VIOLATION SHALL N 2019	FOR THE TYPE B OT EXCEED JULY 15,			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 37 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		FCL078079	B. WING		05/31/2	2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
DIALLS FA	MILV CADE HOME #40	70 CARE D				
DIAL'S FA	MILY CARE HOME #10	PEMBROK	E, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
C 311	Continued From page	e 37	C 311			
C 311	10A NCAC 13G .0909	9 Residents' Rights	C 311			
	all residents guaranted Declaration of Resider and may be exercised. This Rule is not met TYPE A1 VIOLATION. Based on observation reviews, the facility faresidents as evidence feeling uncomfortable mechanical lift devices mechanical lift devices stabilize the lift when failing to have an ongulace to assure the micorrectly by staff and. The findings are: Review of Resident # 03/07/19 revealed: -Diagnoses included a dementia, anemia, gavein thrombosis, hypeinsulin dependent diagastroesphogeal reflutation. There was document constantly disoriented.	hall assure that the rights of sed under G.S. 131D-21, ents' Rights, are maintained d without hindrance. as evidenced by: Ins, interviews and record illed to assure the safety of ed by staff failing to report a using Resident #2's entailing to operate the entailing process in the properly by failing to transferring residents and soing monitoring process in the chanical lifts were used worked properly. 2's current FL-2 dated Alzheimer's disease, estrointestinal bleed, deep certension, atrial fibrillation, betes mellitus, gastritis and itx disease. Itation the resident was				
	Review of Resident # revealed an admissio	2's Resident Register n date of 04/07/11.				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 38 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1.			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
			D MINO			С
		FCL078079	B. WING	·····	05	5/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
DIAL'S EA	MILV CARE HOME #10	70 CARE	DRIVE			
DIAL 5 FA	AMILY CARE HOME #10	PEMBRO	KE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 311	Continued From page	e 38	C 311			
	Review of Resident # plan dated 03/07/19 r documentation the re	2's assessment and care				
	lift transfers. (A mech transfer individuals by body and connecting lift). -There was documen competency validated dated 04/08/19, 01/07 06/08/18 for mechani Review of an "Accide Resident #2 dated 02 -The resident was as:	tasks included mechanical anical lift is a device used to placing a sling under the the sling to the mechanical tation staff were for the quarterly reviews 7/19,12/06/18, 09/05/18, and cal lift transfers. Int/Incident Report" for 1/27/19 revealed: sisted to her room by staff				
	bed" and realized the forgot to "hook" and t -The staff contacted t called 911The Administrator comemberThe resident was ad right hip fracture.	o net to place the resident in re was one "hook" the staff he resident fell to the floor. he Administrator and then ontacted Resident #2's family mitted to the hospital with a tation the Administrator				
	discharged on 03/06/ -There was documen	revealed: mitted on 02/27/19 and 19.				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 39 of 53

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		FCL078079	B. WING		05/31/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE I				
			KE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
C 311	there was an entry or placed in a mechanic in order to be cleaned secured "within the let to the floor. -On 02/24/19 an x-ray pelvis showed a minir the right hip. -The resident underw a intrameduallary nail metal rod forced into treat the fracture). Observation of the liv (PCA) assisting Residusing a mechanical lit revealed: -Resident #2 was pusted bedroom by the live-in-Resident #2's bed was of the roomThe live-in PCA posification of the live-in resident's bed. The live wheels of the Geri chair sideways president's bed. The live wheels of the Geri chair sideways president's bed. The live wheels of the Geri chair sideways president's bed. The live wheels of the Geri chair sideways president's bed. The live wheels of the Geri chair sideways president's bed. The live wheels of the Geri chair sideways president's bed. The live wheels of the Geri chair sideways president's bed. The live wheels of the Geri chair sideways president's bed.	anical fall. e section of the Summary 1 02/27/19, the resident was al lift and moved off her bed I. The resident was not well Ift" and the resident tumbled If of the resident's hip and mally displaced fracture of ent a surgical procedure for fixation of the right hip (a the cavity of the bone to e-in personal care aide dent #2 with transferring if on 05/29/19 at 9:34am shed in a Geri-chair to her in PCA. as against the left long wall tioned Resident #2's is bed and turned the leassed the end of the leassed the end of the lear in PCA pushed the lair in alignment with the	C 311			
	chair and locked the value -The live-in PCA rolle mechanical lift base uthen stopped.					
	9:37pm revealed: -The white colored me Resident #2She did not like this in not have clips and sh	-in PCA on 05/29/19 at echanical lift belonged to mechanical lift because it did e "was not comfortable" comfortable using the blue				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 40 of 53

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER TO CARE DRIVE PEMBROKE, NC. 28372 SUMMARY STATEMENT OF DEPICIENCES PEMBROKE, NC. 28372 CARE DRIVE PEMBROKE, NC. 28372 CONTINUED FROM DEPICIENCY MUSTE REPRECIBED BY PILLL REGULATORY OR LES IDENTIFYING INFORMATION) COLORED III. CONTINUED From page 40 Colored III. -She thought she had to use Resident #2's white colored mechanical lift today (06'30)'19) during the observation of Resident #2's transfer but never used Resident #2's lift and always used the blue colored mechanical lift belonged to another resident in the facility to transfer Resident #2. A second observation of the live-in PCA assisting Resident #2's with transferring using the blue colored mechanical lift belonging to another resident on 00'29'19' as 13'38m revealed: -The live-in PCA to Resident #2's the was going to transfer her from the Geri-chair to the bedResident #2's transfer mesh sling was positioned underneath the resident in the Geri-chair to the bedResident #2's the sing underneath the resident's upper back, sides and kneesThe live-in PCA tolled the base of the mechanical lift under the Geri-chair and positioned underneath Resident #2 and checked the positioning of the sling underneath the resident's upper back, sides and kneesThe live-in PCA tolled the base of the mechanical lift under the Geri-chair and positioned the spreader bar over the center of the patient with the hooks facing away from the resident. The mechanical lift under the Geri-chair and positioned the spreader bar over the center of the patient with the hooks facing away from the resident. The mechanical lift legs were not in an opened positionThe live-in PCA hooked the color-coded sling loops onto the spreader bar with the resident and the black colored loops to support the top portion of the resident and the black colored loops to support the top portion of the resident and the black colored loops to support the top portion of the resident and the black colored loops to support the color-called sing positioned the pread	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
NAME OF PROMDER OR SUPPLIER DIAL'S FAMILY CARE HOME #10 TO CARE DRIVE PEMBROKE, NC 28372 (X4) ID PRETEX TAGE (X4) ID PROMDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCES PEMBROKE, NC 28372 (X4) ID PRETEX TAGE (X4) ID PROMDER OR SUMMARY STATEMENT OF DEFICIENCES PEMBROKE, NC 28372 (X4) ID PRETEX TAGE (X4) ID PRETE				7 11 2012311101			
DAL'S FAMILY CARE HOME #10 TO CARE DRIVE PEMBROKE, NC 28372	l		FCL078079	B. WING		05	_
CAST	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATI	E, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) C 311 C 311 Continued From page 40 colored lift. -She thought she had to use Resident #2's white colored mechanical lift today (05/30/19) during the observation of Resident #2's transfer but never used Resident #2's lift and always used the blue colored mechanical lift today (05/30/19) during Resident #2's lift and always used the blue colored mechanical lift today (05/30/19) during Resident #2's lift and always used the blue colored mechanical lift that belonged to another resident on 05/29/19 at 9:38am revealed: -The live-in PCA removed the white colored mechanical lift from Resident #2's room and brought in a blue colored mechanical lift. -The live-in PCA told Resident #2's how and brought in a blue colored mechanical lift. -The live-in PCA staightened the sides and corners of the meshed sing positioned underneath the resident in the Geri-chair. -The live-in PCA removed the base of the mechanical lift under the Geri-chair. -The live-in PCA removed the sides and corners of the meshed sing positioned underneath the resident #2 and toekked the positioning of the sling underneath the resident #2 and hocked the positioning of the sling underneath the resident #2 and hocked the positioning of the sling underneath the resident #2 and hocked the positioned the spreader bar over the center of the patient with the hooks facing away from the resident. The mechanical lift legs were not in an opened position. -The live-in PCA hooked the color-coded sling loops onto the spreader bar over the colored loops to support the top portion of the resident and the black colored loops to support the	514116 54		70 CARE	DRIVE			
C 311 Continued From page 40 colored liftShe thought she had to use Resident #2's white colored mechanical lift today (05/30/19) during the observation of Resident #2's transfer but never used Resident #2's lift and always used the blue colored mechanical lift that belonged to another resident in the facility to transfer Resident #2. A second observation of the live-in PCA assisting Resident #2' with transferring using the blue colored mechanical lift belonging to another resident on 05/29/19 a 03-38 m revealed: -The live-in PCA removed the white colored mechanical liftThe live-in PCA todd Resident #2's from and brought in a blue colored mechanical liftThe live-in PCA todd Resident #2's the was going to transfer her from the Geri-chair to the bedResident #2's transfer mesh sling was positioned undermeath the resident in the Geri-chairThe live-in PCA straightened the sides and corners of the meshed sling positioned undermeath Resident #2 and checked the positioning of the sling undermeath the resident's upper back, sides and kneesThe live-in PCA rolled the base of the mechanical lift under the Geri-chair and positioned the spreader bar over the center of the patient with the hocks facing away from the resident. The mechanical lift legs were not in an opened positionThe live-in PCA hooked the color-coded sling loops not the spreader bar with the resident and the black colored loops to support the	DIAL'S FA	MILY CARE HOME #10	PEMBRO	KE, NC 28372			
colored lift. -She thought she had to use Resident #2's white colored mechanical lift today (05/30/19) during the observation of Resident #2's Iransfer but never used Resident #2's lift and always used the blue colored mechanical lift that belonged to another resident in the facility to transfer Resident #2. A second observation of the live-in PCA assisting Resident #2 with transferring using the blue colored mechanical lift belonging to another resident on 05/29/19 at 9.38am revealed: -The live-in PCA removed the white colored mechanical lift from Resident #2's room and brought in a blue colored mechanical lift. -The live-in PCA told Resident #2's room and brought in a blue colored mechanical lift. -The live-in PCA straightened the sides and corners of the meshed sling positioned underneath the resident in the Geri-chair to the bed. -Resident #2's transfer mesh sling was positioned underneath Resident in the Geri-chair. -The live-in PCA straightened the sides and corners of the meshed sling positioned underneath Resident #2 and checked the positioning of the sling underneath the resident's upper back, sides and knees. -The live-in PCA rolled the base of the mechanical lift under the Geri-chair and positioned the spreader bar over the center of the patient with the hooks facing away from the resident. The mechanical lift legs were not in an opened position. -The live-in PCA hooked the color-coded sling loops onto the spreader bar with the red colored loops to support the	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
resident's lower portion, then checked each sling loop on the hook with the clips by walking on both sides of the chair checking each loopThe live-in PCA checked the pressure knob,	C 311	colored liftShe thought she had colored mechanical lift the observation of Renever used Resident blue colored mechanianother resident in the #2. A second observation Resident #2 with transcolored mechanical lift resident on 05/29/19 -The live-in PCA remember and the blue colored mechanical lift from Resident #2's transfeunderneath the resident #2's transfeunderneath the resident #2's transfeunderneath Resident positioning of the sling upper back, sides and The live-in PCA rollemechanical lift under positioned the spread patient with the hooks resident. The mechanopened positionThe live-in PCA hook loops onto the spread positionThe live-in PCA hook loops to support the to and the black colored resident's lower portic loop on the hook with sides of the chair che	It to use Resident #2's white ft today (05/30/19) during sident #2's transfer but #2's lift and always used the cal lift that belonged to e facility to transfer Resident of the live-in PCA assisting sferring using the blue ft belonging to another at 9:38am revealed: bowed the white colored desident #2's room and wred mechanical lift. Resident #2 she was going are Geri-chair to the bed. For mesh sling was positioned ent in the Geri-chair. If the gunderneath the resident's did the base of the the Geri-chair and der bar over the center of the stacing away from the nical lift legs were not in an acceptation of the resident loops to support the on, then checked each sling the clips by walking on both cking each loop.	C 311			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 41 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1. 20.2210		
		FCL078079	B. WING		C 05/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
DIALICEA	MILV CARE HOME #40	70 CARE	DRIVE		
DIAL'S FA	MILY CARE HOME #10	PEMBRO	KE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
C 311	Continued From page	÷ 41	C 311		
	cleared checked the passure it was secure at the mechanical lift aw slowly positioned the bed while guiding the suspended sling until in the sling over the barren PCA centrolled and rotated the resection of the bed the pressure knob and guibed.	ered Resident #2 over the esident to face the foot in slowly released the uided the resident onto the elive-in PCA did not widen anical lift legs to the			
	mechanical lift in Febrifell from the lift. -She was assisting Refrom the Geri-chair ar another resident that asking her for a glass securing the resident transfer the resident. -She remembered as the other resident she then noticed she had linen savers on Resid the process of securing the incontinent linen securing the medouble check to assure	evealed: desident #2's white colored ruary 2019 after the resident desident #2 back to the bed and became distracted by came to Resident #2's door of milk as she was s sling loops to lift and deshe turned around to tell de would be right there, she not placed any incontinent dent #2's bed and stopped in desident #2's b			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 42 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		A. BUILDING			
	FCL078079	B. WING		0.5	C 5/31/2019
	•	!		1 00	70172010
NAME OF PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
DIAL'S FAMILY CARE HOME #10	70 CARE	DRIVE DKE, NC 28372			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
C 311 Continued From page	e 42	C 311			
mechanical lift and w from the chair, Resid and onto the floor. -Since Resident #2 fe always physically wa make sure all of the secured instead of ju hooks. -She had not used Remechanical lift since 2019. -She had never felt c #2's mechanical lift "a hook the sling loops I -She had never ment to the medication aid (MA/SIC) that she was Resident #2's mechanical lift when she was initities and previous experien lift when she was inititiesShe thought years a demonstration using for someone but was observed or passed of professionalShe "seldom" widen maximum opened poresidents' in the medical in the medical control of the core in the maximum opened poresidents' in the medical control of the core in the lift under the Gerical control of the core in the maximum opened poresidents' in the medical control of the lift under the Gerical control of the core in the lift under the Gerical control of the lift under the Gerical control of the lift under the Gerical control of the lift under the li	when she pulled the lift away ent #2 fell out of the sling ell from the lift she now lks around the chair or bed to sling loops were hooked and st leaning over to check the esident #2's white colored the incident in February omfortable using Resident anyway" because it did not like the other residents' lifts. tioned to the Administrator or e/supervisor-in -charge as uncomfortable using inical lift. the facility since 2007. y prior PCA experience and ice operating a mechanical ially hired. job training from a e of the residents' go she had to do a return a residents' mechanical lift in to sure if she was off by a nurse or medical ed the lift's base to the sition when transferring hanical lifts. The mechanical leg base to fit inchair. at widening the base of tabilized the lift to prevent				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 43 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL078079	B. WING		C 05/31/2019
					1 00/01/2013
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
DIAL'S FA	MILY CARE HOME #10	70 CARE PEMBRO	DRIVE DKE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
C 311	finish. A third observation of at 2:04pm revealed: -The live-in PCA assis in a wheelchair to her The live-in PCA locke wheelchair and explait that she was going to wheelchair to the bed-The live-in PCA wide mechanical lift legs as around the front of the kept the lift legs in the during the resident's owheelchair to the bed A third interview with at 2:10pm revealed: -Since the incident ocwith Resident #2 fallir	ess of transferring a nanical lift from start to the live-in PCA on 05/30/19 sted another resident sitting room. d the wheels of the ined to the other resident transfer her from the . ned the base of the she positioned the lift e resident's wheelchair and a maximum opened position complete transfer from the	C 311		
	transferred residents had started practicing everything was secure transferring and movil lifts. -She did not know if the available for instruction for the other the home that belonger. No one had ever revisinstructions with her coprecautions that should be a started transferred t	using mechanical lifts and safety checks to make sure e and in position before ng residents in mechanical here was an owner's manual ons on the use of Resident an owner's manual for use her two mechanical lifts in ed to the other residents.			
		Resident #2's hospice			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 44 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL078079	B. WING		05	C 5/ 31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE	DRIVE			
DIALOTA	MILI GARL HOME #10	PEMBRO	OKE, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
C 311	Continued From page	e 44	C 311			
	could qualify for a new the resident had this years.	/19) to see if the resident w mechanical lift because same mechanical lift for				
	05/30/19 at 10:05am -There was sticker or mechanical lift that pr of the lift and the nam equipment provider (I -There was a suspen six-point curved hook	the center bar of the covided a number for service ne of the durable medical DME). ded spreader bar with s to attach the patient lift uipped with clips at the end as were curved and				
	Attempted telephone company for Residen	interview with the DME t #2's mechanical lift on nd on 05/31/19 at 2:08pm				
	-There was a labeled instructions printed in -There were instruction should operate the education -Whenever possible the present during lifting and -To ensure safety, free equipment and its acceptance of the present during lifting and the safety	/31/19 at 3:12pm revealed: "Caution" sticker with red font. ons trained caregivers only quipment. wo caregivers should be and transferring. quent inspections of this				
	Observation of the me	echanical lift used to transfer				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 45 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COMI LETED
					С
		FCL078079	B. WING		05/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
DIAL'S FA	MILY CARE HOME #10	70 CARE [DRIVE		
DIALOTA	MIET GARE HOME #10	PEMBRON	KE, NC 28372		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
C 311	Continued From page	e 45	C 311		
	Resident #2 on 05/30 hooks with movable of suspended spreader	/19 revealed a 6-point lips at the ends on the			
	mechanical lift used to 05/30/19 revealed:	o transfer Resident #2 on please read and adhere to			
	the safety precautions so could result in seri damage to your perso	s and warnings. Failing to do ous personal injury or			
	lift by having it service -There was an entry l				
	adhere to the operation anyone.	ng instructions prior to lifting			
	There was a second of that it was strongly re caregivers take part in				
	-There was a third en ensure stability while	try labeled "WARNING" to lifting and transferring a			
	maximum open positi	legs must be locked in the on. ntry labeled "WARNING" to			
	ensure the lifting sling attached to the hooks sliding or falling out o	g loops were correctly to prevent the patient from f the sling, which could			
	result in personal inju	ry.			
	Interview with the Adr 3:50pm revealed:	ministrator on 05/30/19 at			
	-The facility did not hat procedure for the use mechanical lifts and "	ave a written policy and of the residents' they" just had the staff e of the mechanical lifts			
	before the staff used -She was not aware t	the lifts. hat the live-in PCA was not sident #2's mechanical lift			

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 46 of 53

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		С		
		FCL078079	B. WING		05/31/201	9
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE D				
			E, NC 28372			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	(X5) MPLETE DATE
C 311	Continued From page	2 46	C 311			
	received training and mechanical lift when seemployment at the factorial seemployment at the factorial seemployment at the factorial seemployment at the factorial seemployment in a mechanical mechanical lift in Feberal seemployment including and that "maybe it was provided any addition incident occurred whe mechanical lift in Feberal seemployment including and mechanical lift in Feberal seemployment in	#2 today (05/30/19) had was passed off to use a she first began her cility. The live-in PCA transfer a cal lift in the past but could al training would be needed as her fault" that she had not al training for staff after the ten Resident #2 fell out of the truary 2019. The ected for staff to inform her there is not comfortable using the live-in PCA was not the base of the lift when				
	(BOM) on 05/30/19 at -She was not aware of the facility had to ensincluding mechanical working properlyShe thought "we" neplace to have the equathe facility to make suserviced and working -She was not aware to facility did not feel commechanical lift. Interview with Reside 05/31/19 at 10:57am -She never saw staff #2's mechanical lift be always up in the Geri-	of a process or procedure ure all resident equipment lifts had been serviced or eeded to put something into upment suppliers come to ure the mechanical lifts were properly. hat any of the staff in the mfortable with Resident #2's				

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 47 of 53

	or realth Service Negu		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		TOYAL BATE OLIDIYEY
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
, , , , , , , , , , , , , , , , , , , ,	5. 55. u. 25. u. 3. u	152.111116/11161115211	A. BUILDING: _		00
					С
		FCL078079	B. WING		05/31/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OF T	NOVIDEN ON OUT FIELD	70 CARE		, Z.II	
DIAL'S FA	MILY CARE HOME #10		KE, NC 28372		
			TRE, NC 20372		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI	
				DEFICIENCY)	
C 311	Continued From page	. 47	C 311		
0 0 1 1			0 0 1 1		
	safety for staff to repo	ort if they were not			
	comfortable using Re	sident #2's mechanical lift.			
		vith the facility's contracted			
	LHPS nurse on 05/31	/19 at 1:58pm and at			
	4:02pm revealed:				
		providing LHPS quarterly			
		around the Fall of 2018.			
		off" on the staffs' skills to			
	perform mechanical li				
	_	ave a system in place to			
	_	echanical lifts to make sure			
		s and safety steps were			
		otect the residents' safety.			
		ame with an instruction			
		e mechanical lifts were the			
	same.				
	Interview with the MA	/SIC on 05/31/19 at 4:09pm			
	revealed:	7010 011 00/3 1/ 13 at 4.03pm			
		ave a policy for the use of			
	the residents' mechan				
	transferring.	near into about for			
	-There were no manu	als available for the			
	residents' mechanica				
	-The previous nurse t	hat done training for staff			
		S quarterly reviews had			
	passed away.	,			
		anical lifts were not on a			
	scheduled service pla				
		sk the DME supplier to look			
		made visits to the facility to			
	bring other DME equi	_			
	-He remembered a D	ME staff person did look at			
		nical lift about 2 months ago.			
		nechanical lifts in the facility			
		to report if a mechanical lift			
	was not working prop				
		not made him aware that			
	she was uncomfortab	le and not using Resident			

Division of Health Service Regulation

STATE FORM 8899 2B5T11 If continuation sheet 48 of 53

DIVISION	n Health Service Regu	ialion				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		1	_	_		
		D WING		C		
		FCL078079	B. WING		05/3	1/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	TOVIDER OR SOLT LIER			TE, ZII GODE		
DIAL'S FA	MILY CARE HOME #10	70 CARE I				
		PEMBROK	E, NC 28372			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
			1	DEFICIENCY)		
C 311	Continued From page	- 48	C 311			
	Continued i form page	2 40				
	#2's mechanical lift fo	or transfers.				
	-He just had a meetin	g the first of May 2019 and				
	=	if they had any concerns				
	with any resident equ					
	mentioned any conce	•				
		RN) had been contacted				
		ass off and train staff in the				
	• • • • • • •	Il lifts used to transfer the				
	residents. The RN wa	as scrieduled to come				
	Monday 06/03/19.					
	-If he had known the live-in PCA was not					
	comfortable using Resident #2's mechanical lift					
	then he could have had a refresher course set-up					
	for the staff.					
	Interview with a secon	nd live-in PCA on 05/31/19				
	at 2:22pm revealed:					
	-She used Resident #	[‡] 2's mechanical lift and did				
	not have any problem	ns using it.				
	-If she saw a problem					
	equipment then she would not use it and report it					
	immediately to the MA/SIC or the Administrator.					
	-Resident #2's mechanical lift was "old" and never					
	had any clips on the					
	• •	of a owner's manual for				
	Resident #2's mechai					
		esident #2's mechanical lift				
		r to connect the sling and				
	secure the sling into p					
		down on the loops to make				
		secure and against the hooks				
	bar before lifting Resi	dent #2 with the mechanical				
	lift.					
	-She was trained and	had to give a returned				
		use a mechanical lift to				
		nen she started back in				
	2017.					
		at widening the base of the				
		ed the stability of the lift				
	modianical intensule	ou une stability of the lift	1			

Division of Health Service Regulation

during transfers and could have been told that in

STATE FORM 8899 2B5T11 If continuation sheet 49 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		X3) DATE SURVEY COMPLETED	
						С	
		FCL078079	B. WING		05	5/31/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	F ZIP CODE	•		
		70 CARE		_,			
DIAL'S FA	MILY CARE HOME #10		KE, NC 28372				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
C 311	Continued From page	÷ 49	C 311				
	training, but was not	sure.					
	3:22pm revealed: -She did not monitor to assure the lifts were with the live-in PCAs working the lift was working. She had seen one of mechanical lift to tran weeks and the base of widened. Telephone interview widened. Telephone interview widened: -She expected staff to sling to a mechanical transferring a resident transferring a resident a staff person felt widened. Resident #2's mechan have been reported in Administrator for the staff person	working properly because ing with the lifts would know properly or not. If the live-in PCAs use a sfer a resident in the last 2 of the mechanical lift was with Resident #2's primary on 05/30/19 at 5:22pm If always assure the transfer lift was well secured prior to the safety of the resident. If the mechanical lift was well secured prior to the safety of the resident. If the safety of the resident. If the lift was well staff to be trained on the					
	as evidenced by staff uncomfortable using I device, failing to oper device properly by no	ssure the safety of residents failing to report feeling Resident #2's mechanical lift ate the mechanical lift t following safety steps idents and failing to have an					
	ongoing monitoring promechanical lifts were worked properly. The resulted in Resident # being transferred by a	rocess in place to assure the used correctly by staff and facility's failure which to being dropped while a staff who did not follow acility's failure resulted in 19 a hip fracture and					

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 50 of 53

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		FCL078079	B. WING		C 05/31/2019			
			DDD500 0171/ 074	T. J.D. 0.0.5	05/51/2019			
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 70 CARE DRIVE							
DIAL'S FA	DIAL'S FAMILY CARE HOME #10 PEMBROKE, NC 28372							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE			
C 311	Continued From page	: 50	C 311					
	physical harm and ne							
		as submitted by the facility S. 131D-34 on 05/31/19.						
	CORRECTION DATE VIOLATION SHALL N 2019	FOR THE TYPE B OT EXCEED JUNE 30,						
C 912	G.S. 131D-21(2) Decl	aration of Residents' Rights	C 912					
	Every resident shall h 2. To receive care an adequate, appropriate	ation of Resident's Rights ave the following rights: d services which are e, and in compliance with tate laws and rules and						
	reviews, the facility fa had the right to receiv are adequate, approp with rules and regulat management and oth	is, interviews, and record filed to assure every resident e care and services, which riate, and in compliance fions as related to er staff, healthcare referral and food service and						
	The findings are:							
	reviews, the facility fa diets were served as resident who was diag dementia and had an (Resident #2). [Refer	ions, interviews and record iled to assure therapeutic ordered for 1 of 1 sampled gnosed with advanced order for a pureed diet to Tag 284 10A NCAC 13G and Food Service (Type B						

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 51 of 53

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED		
		FCL078079	B. WING		C 05/31/2019		
					1 05/3	1/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
DIAL'S FA	MILY CARE HOME #10	70 CARE D	RIVE E, NC 28372				
240.15	CLIMMADY CT.		1	DROVIDEDIS DI ANI OF CORRECTION		0.450	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
C 912	Continued From page	2 51	C 912				
	reviews, the facility fa was equipped and ma sampled (#1, #2, #3, and/or cognitively una independently. [Refer .0302(b) Design and Violation)].						
	3. Based on observations, interviews, and record reviews, the facility failed to assure referral and follow-up with the primary care provider for 1 of 4 sampled residents related to a resident having trouble swallowing her food for at least a week (Resident #4). [Refer to Tag 246 10A NCAC 13G .0902(b) Health Care (Type B Violation)].						
	reviews, the facility fa on duty and awake at personal care and sup sampled residents (R #5). [Refer to Tag 019	ions, interviews, and record illed to have sufficient staff all times to meet the pervision needs for 4 of 6 esident #1, #2, #3, #4 and 91 10A NCAC 13G .0601(d) her Staff (Type B Violation)].					
C 914	G.S 131D-21(4) Decla	aration Of Resident's Rights	C 914				
	-	nave the following rights: al and physical abuse, ion.					
	reviews, the facility fa	as evidenced by: ns, interviews and record illed to ensure residents elated to Residents' Rights.					
			I				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 52 of 53

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
FCL078079		B. WING		05/3			
NAME OF P	FCL078079 B. WING 05/31/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
DIAL'S FAMILY CARE HOME #10 70 CARE DRIVE PEMBROKE, NC 28372							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE	
C 914	Based on observation reviews, the facility faresidents as evidence feeling uncomfortable mechanical lift device mechanical lift device stabilize the lift when failing to have an ong place to assure the mecorrectly by staff and	ns, interviews and record iled to assure the safety of ed by staff failing to report using Resident #2's , failing to operate the	C 914				

Division of Health Service Regulation

STATE FORM 2B5T11 If continuation sheet 53 of 53