	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL046021	B. WING		R 10/04/2023
	PROVIDER OR SUPPLIER	HOME 316 EAS	DDRESS, CITY, TRICHARD E, NC 27910		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
C 000	Initial Comments		C 000		
	The Adult Care Lice annual and follow-u	nsure Section conducted an p survey on 10/04/23.			
C 100	10A NCAC 13G .03 Disaster Plan	16 (e) Fire Safety And	C 100		
	10A NCAC 13G .03 Plan	16 Fire Safety And Disaster			
	fire evacuation plan rehearsals shall be r furnished to the cou- services annually. T date and time of the	t least four rehearsals of the each year. Records of maintained and copies nty department of social he records shall include the rehearsals, staff members description of what the			
	reviews, the facility fa evacuation plans (fin least four times year	as evidenced by: ns, interviews, and record ailed to ensure that fire e drills) were rehearsed at y resulting in 4 of 4 residents uate the facility without		The Administr Will ensure the rule is Met; by four rehearsa	ator Ilaba atthis having
	Department of Health Division of Health Se certificate revealed: The facility's license The facility's license	s State of North Carolina and Human Services, rvice Regulation license was issued on 01/01/23. d capacity was 5 residents	e	four rehearsa evacuations per Records will b maintained - th Will evacuate th	e e
sion of Hea	and all ambulatory. Ith Service Regulation DIRECTOR'S OR PROVIDEN	VSUPPLIER REPRESENTATIVE'S SIGN Rollston 88	E.	Without prompting Will include parts Administrator 18C11	- A LIST Cipant Skib DATE 11/14/202 If continuation sheet 1 of 23
Revi	ewed and Ackno	wledged 11/27/23-MB		NOV 2 7 2023	Ð

ADULT CARE LICENSURE SECTION RALEIGH

Division of Health Service Regulation

STATEMEN AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL046021	B. WING		R 10/04/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	10/04/2023
STEPHE	NSON FAMILY CARE	HOME 316 EAS	T RICHARD	STREET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE PPROPRIATE DATE
	Interview with the A 8:15am revealed the Requests for the facility policy available for r Review of the facility revealed: -There was docume conducted on 10/02 residents out of the designated meeting -There was docume conducted on 08/30.	dministrator on 10/04/23 at e current census was 4. cility's fire safety policy on here was no facility fire safety review. y's fire drill rehearsal records entation of a fire drill /23 at 9:30am with all building and at the place in 6 minutes. ntation of a fire drill /22 and 11/09/21 with all t the fence (no evacuation	C 100	Date-time-a Shart descript What the rehe Involved.	nd a 11/2/2003 tion of carsal
	Observation of a fire between 9:43am and There were 3 reside the front living room bedroom. The Administrator s second story above loud beeping sound. The fire alarm was a facility and out in the Upon hearing the fir on the living room co at each other and the Administrator and su response to evacuate The fourth resident the den and sat in a others in the room. None of the resident The alarm silenced a 9:46am and 9:47am.	e drill conducted on 10/04/23 d 9:53am revealed: ents sitting on the couch in and 1 resident in his ounded the fire alarm on the the den at 9:43am creating a audible throughout the entire front yard. e alarm, the three residents buch did not move but looked en looked at the irveyors, with no independent		the alarm =	ts, upon ire a barm it the ediately- who me. Once
rision of Hea ATE FORM	At 9:47 am, the Adm Ith Service Regulation		⁹⁹ Z(28011 Build	ilicontinuation sheet 2 of 23

Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER:	A. BUILDING:		
		FCL046021	B. WING		R 10/04/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE	10/04/2023
OTEDUE			T RICHARD		
SIEPHE	NSON FAMILY CARE	NUME	, NC 27910		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DNI IVE
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
C 100	Continued From pa	ige 2	C 100		
	the fire alarm and a to the fire alarm. Interview with a res and 9:49am reveale -The facility rarely h had fire drills about could not remembe occurred.	ad fire drills; he thought they every four months, but he r when the last fire drill			
	 -He came out of his room when the alarm sounded. -He sat down in the den when he did not see others responding to the alarm. -He thought the alarm was being tested. -He usually went outside to the fence but did not think it was a fire drill. Observation of residents on 10/04/23 at 9:52am revealed: -The fire alarm sounded again from the second story level unexpectedly at 9:52am. -All 4 residents immediately exited through the front door of the facility and were observed to gather at the fence on the side of the facility by 09:53am without verbal prompting. 				
	4:26pm revealed: -She conducted fire during the day. -She was responsibl conducted at least q -Each fire drill should it was an oversight th documented each tir -She thought the res because of the surve	dministrator on 10/04/23 at drills monthly and usually le for ensuring fire drills were uarterly. d have been documented and hat the fire drills were not me they were conducted. idents were confused ey team and did not respond typically did, during the fire			

STATE FORM

6899

ZQ8C11

If continuation sheet 3 of 23

Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED		
		FCL046021	B. WING		R 10/04/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	1010112020	
STEPHE	NSON FAMILY CARE		T RICHARD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
C 102	Equipment 10A NCAC 13G .03 Equipment (a) The building and mechanical, and plu	17 (a) Building Service 17 Building Service d all fire safety, electrical, imbing equipment in a family maintained in a safe and	C 102			
	failed to ensure fire a maintained in a safe to a smoke detector properly due to a dea The findings are: Observation of the fa intermittently from 8: -There was an audib detector however de detector was beeping -There was a smoke each resident room of storage room off the -There was no menti beeping by staff.	acility on 10/04/23 because of the facility safety equipment was operating condition related that was not functioning ad battery. acility on 10/04/23 15am-11:30am revealed: le beeping of a smoke termining which smoke g was unsuccessful. detector in the hallway, in off of the hallway and in the hall. on of the smoke detector		The Administrator Changed one of the Smoke detector batteries from What it appeared the beep was coming after words the b Stepped - All of the Smoke detectors in facility were replace 2/2023-Administrate Called the Cempany inform them that one before were beep they stated that the	ere from peeping e the din or to of the	

STATE FORM

6899

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If continuation sheet 4 of 23

Division of Health Service Regulation

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FCL046021		FCL046021	B. WING		R 10/04/202	2
STEPHENSO	IDER OR SUPPLIER	HOME 316 EAS AHOSKIE	DRESS, CITY, T RICHARD , NC 27910		10/04/202	.0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COME	(5) PLETE ATE
Inte 8:44 -The 202 -Sha smo prev com deta -The stop -Sha stop -Sha stop -Sha stop -Sha stop -Sha stop -Sha rega 10/0 -The proc -Sha stop -Sha stop -Sha stop -Sha stop -Sha stop -Sha stop -Sha stop -Sha stop -Sha stop -The proc -Sha stop -Sha stop -The proc -Sha stop -The proc -Sha stop -The proc -Sha stop -Sha stop -The proc -Sha stop -Sha stop -Sha stop -The proc -Sha stop -Sha stop -The proc -Sha stop -Sha stop -The proc -Sha stop -The stop -Sha stop -The stop -The stop -Sha stop -The stop -Sha stop -The stop -Sha stop -The stop -Sha stop -The stop -Sha stop -The stop - Sha stop - The stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha stop - Sha - - Sha - - - Sha - - - - - - - - - - - - - - - - - - -	4am revealed: e smoke detector 3. e contacted the oke detectors in vious week after apleted because actor in the attic. e beeping began oped until yester e bought batterie nge out the batter oped. ond interview with 24/23 at 4:26pm are was no fire p cess for fire drills e contacted the f arding the smoke 3/23, but he had facility. e company that m not been contac ctors. vas important the erly in case them d get out quickly. facility failed to e maintained in sa enced by a beep red by staff. This th, safety and we titutes a Type B	dministrator at on 10/04/23 at ors were replaced in February company that replaced the February 2023 the during the a construction survey was of concerns with the heat the week prior, but it had day (10/03/23). as for replacement but did not eries because the beeping th the Administrator on revealed: olicy available except for a acility's maintenance staff e detector beeping on been unable to come out to eplaced the smoke detectors ted about the beeping smoke e smoke detectors functioned e was a fire so everyone ensure fire safety equipment afe operating condition as ing smoke detector that was was detrimental to the elfare of the residents and	C 102	All of the smoke a Batteries have been replaced and the de are No longer beep The Administrator ensure that the s detectors are mon and maintained as so that there are n batteries or any o issues with the de detectors.	ens ilple exectores ping. Will make tored Needed-mi o dem	R on the

FCL046021 B. WIT NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, STEPHENSON FAMILY CARE HOME 316 EAST RICH AHOSKIE, NC 2 4400000000000000000000000000000000000	27910	R 10/04/2023
STEPHENSON FAMILY CARE HOME 316 EAST RICH AHOSKIE, NC 2 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX C 102 Continued From page 5 C 10 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 18, 2023. C 148 10A NCAC 13G .0406 (a)(8) Other Staff Qualifications C 144 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: C 144 (B) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: -There was no hire date documented.	CHARD STREET	1 10/04/2023
(X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Interpretection PREFIX C 102 Continued From page 5 C 10 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 18, 2023. C 148 10A NCAC 13G .0406 (a)(8) Other Staff Qualifications C 144 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: C 144 (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: -There was no hire date documented.	27910	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRE TA C 102 Continued From page 5 C 10 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 18, 2023. C 148 10A NCAC 13G .0406 (a)(8) Other Staff Qualifications C 144 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: C 144 (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: -There was no hire date documented.		
THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED November 18, 2023. C 148 10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: -There was no hire date documented.	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLE
 VIOLATION SHALL NOT EXCEED November 18, 2023. C 148 10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: There was no hire date documented. 	102	
Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: -There was no hire date documented.		
 (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: -There was no hire date documented. 	148	
Based on observations, interviews, and record reviews, the facility failed to ensure examination and screening for the presence of controlled substances was completed upon hire and results documented for 1 of 2 staff (A) sampled. The findings are: Review of Staff A's (Administrator) personnel record revealed: -There was no hire date documented.		
aide (MA) at the facility. -There was no documentation that an	The Administrator recieved a comp screening/frem Center. The Adm Will ensure tha Staff member wo a complete drug from a medical upon hike.	ete drug a medical nini strator at-each
examination and screening for the presence of a controlled substance had been completed. Observation of the Administrator's personnel record revealed:		
-There was an empty box labeled at home drug		

STATE FORM

6899

ZQ8C11

If continuation sheet 6 of 23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					ATE SURVEY	
			A. BUILDING:			
	FCL046021		B. WING			२)4/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STEPHE	NSON FAMILY CARE	AHOSKIE	T RICHARD , NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 148	test for marijuana. -The Administrator's pen across the top of -There was an expir of the box with 11/20 Interview with the Ad 4:16pm revealed: -She was the Admin MA. -She administered m -She thought the at was sufficient for the -She thought she had home drug test for m the test and the resu -She had forgotten to documenting the dat -She was not aware	a name was written with an ink of the empty box. ration date stamped at the end 016. dministrator on 10/04/23 at istrator of the facility and an nedications at the facility. home drug test for marijuana e required drug screening. Id written on the box of the at narijuana the date she took lts. o complete a form te of her test and the results. eted a drug screening for	C 148			
	 (b) Exceptions. Peo (1) for treatment of a drug abuse; (2) for maternity car (3) for professional a continuous medical s (4) for lodging, when and supervision offer are not needed; or 	1 Admissions Of Residents ople are not to be admitted: mental illness, or alcohol or e; nursing care under	C 201			

6899

If continuation sheet 7 of 23

Division of Health Service Regulation

STATEMEI AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 3:	(X3) DATE SURVEY COMPLETED	
	FCL046021		B. WING		R 10/04/2023	
	PROVIDER OR SUPPLIER	HOME 316 EAS	DRESS, CITY, T RICHARD , NC 27910		1. 10/0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
	safety of others. This Rule is not me Based on interviews facility failed to ensu (#1) was not admitted mental illness. The findings are: Review of Resident 08/31/22 revealed: -Diagnoses included without intellectual in depressive disorder -There was an order used to treat depress Review of Resident revealed he was admit Review of Resident plan dated 08/21/23 independant with ear bathing dressing and staff supervision for Review of Resident a Verificaton Process of Resident #1 was bei a social worker with he was admitted on the Interview with Resident	et as evidenced by: s, and record reviews, the ure 1 of 3 sampled residents ed for the treatment of a #1's current FL-2 dated d autism spection disorder mpairment and major r for 1 medication that was sion. #1's Resident Register mitted on 03/26/21. #1's assessment and care revealed he was ting, toileting, ambulation, d transfering and required grooming. #1's Referral Screening dated 03/19/21 revealed ng referred for placement by the psychiatric hospital where 01/21/20. ent #1 on 10/04/23 at e had no medical problems	C 201	The Administra Will ensure th residents are an according to the and regulations	amite	a
	Interview with the Ad alth Service Regulation	ministrator on 10/04/23 at				

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		FCL046021	B. WING			R 04/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	, STATE, ZIP CODE	1 10/0	7412023	
STEPHE	NSON FAMILY CARE	AHOSKIE	T RICHARD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / 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	(X5) COMPLETE DATE	
C 201	psychiatric hospital. -Resident #1 did no -She was not aware	dmitted from a state	C 201				
	to meet the routine a of residents. This Rule is not me Based on observation reviews, the facility for residents (#2) who we an appointment with nondisplaced fracture bone on the left foot attended a follow up psychiatrist following inpatient behavioral The findings are: Review of Resident 08/09/23 revealed:	02 Health Care I assure referral and follow-up and acute health care needs that as evidenced by: ons, interviews, and record failed to ensure 1 of 3 was newly admitted attended to a podiatrist for a closed re of the second metatarsal without routine healing and o appointment with a g a discharge from an health hospitalization. #2's current FL-2 dated	C 246	This resident has attended his peo Appointment, he h Continued to get feet soaked each (Pm) and the onic Applied to each + After the appoint	his his Dintm Cot.	enf F	
	bipolar type, mild intr asthma. -The resident was in ambulatory. Review of Resident a revealed the residen	I schizoaffective disorder ellectual disability, and termittently disoriented and #2's resident register t was admitted on 08/11/23. #2's Care Plan dated		the Podiatrist ch the foot soak to The Administrato Ensure that the Will Continue to his feet.	anged PRN. r Will	1	

STATE FORM

ZQ8C11

If continuation sheet 9 of 23

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
FCL046021		FCL046021	B. WING		R	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/04/2023	
STEPHE	INSON FAMILY CARE	AHOSKIE	FRICHARD , NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
	toileting and groomi -The resident requir bathing. -The resident receiv and was referred for a. Review of a disc #2 dated 08/10/23 r -The resident was d behavioral health ho diagnosis of schizoa without a good prog nondisplaced fractur bone on the left foot second metatarsal b the second two local ankle). -The resident had a scheduled with a por fracture of the secon foot. Observation of Resid 1:58pm revealed: -The resident was all -His great toenail on long extended from the -There was a black of a thin line that began from the arch of his foo -His great toenail on on the black dried su was where his skin w shoe covered his foo -His great toenail on	ed limited assistance with ng. ed extensive assistance with red mental health services r mental health services. harge summary for Resident evealed: ischarged from an inpatient ospital on 08/10/23 with a offective disorder bipolar type nosis and a closed re of the second metatarsal without routine healing (the one is the long thin bone of ted between the toes and the follow up appointment diatrist on 09/05/23 for a and metatarsal bone in his left dent #2's feet on 10/04/23 at ble to remove his shoes. his right foot was ¾ inch the tip of his toenail. on his right foot was ½ inch the tip of his toenail. If ied substance in the form of a the inside of his right foot foot that wrapped around the en the resident had his shoes ibstance that formed a line vas exposed above where his	C 246	The Administrate Will ensure that the resident is premp and assisted in the daily. The Administ will ensure that the resident has require foot care. Finch Nail care and st Care.	re sted sathing rator he ar	

STATE FORM

ZQ8C11

If continuation sheet 10 of 23

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		FCL046021	B. WING		1	R 04/2023
AME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
TEDUE	NSON FAMILY CARE	040 540	RICHARD			
	NSON FAMILY CARE		, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLE DATE
C 246	Continued From page	ge 10	C 246			
	inch extended from extending upward. -There was dried, cr great toenail.	great toenail on his left foot ¼ the base of his toenail racking skin around his left racking skin to the right of his				
	Interview with Resident #2 on 10/04/23 at 1:37pm revealed: -His left foot felt achy at times, but he was able to walk without any problems. -He had not been to a podiatrist appointment since he was admitted to the facility.					
	podiatrist office on 1 -Resident #2 had a f scheduled with the p	with a receptionist at a local 0/04/23 at 2:25pm revealed: follow up appointment odiatrist on 09/05/23. no show for the appointment.				
	10:56am revealed: -The resident's walke times and were achy -When she received paperwork at his adr discharge informatio up appointment sche -She should have ad appointment to the fa	Iministrator on 10/04/23 at ed often but his feet hurt at where he had a fracture. the resident's discharge nission, she reviewed his n but did not see the follow eduled with a podiatrist. ded the resident's podiatrist acility calendar to ensure he ment with the podiatrist.				
	#2 dated 08/10/23 re -The resident was dis behavioral health hos -The resident had a f	scharged from an inpatient			8	

Division of Health Service Regulation STATE FORM

6899

PCL046021 B. WNO R. WNO R. WNO STEPFLENSON FAMILY CARE HOME 316 EAST RICHARD STREET AHOSKIE, NC 27910 316 EAST RICHARD STREET AHOSKIE, NC 27910 PROVIDERS PLAN OF CORRECTIVE AND SHOULD BE CROSS-REFERENCE AN	STATEME AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED	
Image: Provide or supplier FCL04621 B_WRC 10/04/2023 NAME OF PROVIDER OR SUPPLIER STREETADDRESS, GITY, STATE, ZIP CODE 316 EAST RICHARD STREET STEPHENSON FAMILY CARE HOME 316 EAST RICHARD STREET AHOSKIE, NC 27910 C0010 SUMMAY STATEMENT OF DEFICIENCIES D PREFIX C246 Continued From page 11 C 246 Continued From page 11 C 246 Telephone interview with a receptionist with the psychiatrist office on 10/04/23 at 1:24pm C 246 Continued From page 11 C 246 The resident #2 on 10/04/23 at 1:24pm revealed: -The resident #2 on 10/04/23 at 1:37pm FREFIX DEFICIENCY revealed: -He had been at the facility for a month and a hat. C 246 Continued From page 11 The full form form form forment is borrithery Interview with Resident #2 on 10/04/23 at 1:37pm revealed: D/// Continued From page 11 C 246 Interview with Resident #2 on 10/04/23 at 1:37pm revealed: D/// Continued From page 11 The full forment is borrithery Interview with the administrator on 10/04/23 at 1:37pm revealed: D/// Continue forment is borrithery -She reviewed the resident's discharge paperwork when he was admitted but had overloade the soptial rist. D/// Continue forment is borrithery C249 10A NCAC 133 .0902 (Health Care C 249 Sending @ut @uppointmen							
STEPHENSON FAMILY CARE HOME 316 EAST RICHARD STREET AHOSKIE, NC 27910 SUMMARY STATEMENT OF DEFICIENCIES RECAT DEFICIENCY MUST BE PRECEDED BY FULL Reconstruction of the provident and the pr			FCL046021	B. WING			
AHOSKIE, NC 27910 PACH ID SUMARY STREEMENT DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENT ANALOF CORRECTION (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENTIFYING INFORMATION (CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSC DENTIFYING INFORMATION) PROVIDENTIFYING INFORMATION (CACH DATA AND AND AND AND AND AND AND AND AND AN	NAME OF	PROVIDER OR SUPPLIER					
PREFIX TAC TAC <t< td=""><td>STEPHE</td><td></td><td>AHOSKIE</td><td></td><td></td><td></td></t<>	STEPHE		AHOSKIE				
 Telephone interview with a receptionist with the psychiatrist office on 10/04/23 at 1:24pm revealed: Resident #2 had a follow up appointment scheduled with the psychiatrist on 09/22/23. The resident was a no show for the appointment. Interview with Resident #2 on 10/04/23 at 1:37pm revealed: He had been at the facility for a month and a haff. He had been to see a psychiatrist since he was admitted to the facility. Interview with the Administrator on 10/04/23 at 10:56am revealed: She reviewed the resident's discharge paperwork when he was admitted by inpatient behavioral health hospital. She should have added the resident's psychiatrist appointment with a psychiatrist. C 249 10A NCAC 13G.0902(c)(3)(4) Health Care (c) The facility scalendar to ensure he attended his scheduled appointment with the psychiatrist. C 249 10A NCAC 13G.0902(c)(3)(4) Health Care (c) The facility scalendar to ensure health procedures, treatments or orders from a physician or other licensed health professional; and (4). Implementation of procedures, treatments or orders from a physician or diver specified in Subparagraph (c)(3) of this Rule. 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETE	
 psychiatrist office on 10/04/23 at 1:24pm revealed: -Resident #2 had a follow up appointment scheduled with the psychiatrist on 09/22/23. -The resident was a no show for the appointment. Interview with Resident #2 on 10/04/23 at 1:37pm revealed: -He had been at the facility for a month and a half. -He had not been to see a psychiatrist since he was admitted to the facility. Interview with the Administrator on 10/04/23 at 10:56am revealed: -She reviewed the resident's discharge paperwork when he was admitted but had overlooked the follow up appointment with a psychiatrist haves scheduled by inpatient behavioral health hospital. -She should have added the resident's calendar to ensure he attended his scheduled appointment with the psychiatrist. C 249 10A NCAC 13G .0902(c)(3)(4) Health Care (c) The facility scalendar to ensure he attended his scheduled appointment with the psychiatrist are record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. 	C 246	Continued From pa	ge 11	C 246			
ivision of Health Service Regulation		Telephone interview psychiatrist office or revealed: -Resident #2 had a scheduled with the p -The resident was a Interview with Resid revealed: -He had been at the half. -He had not been to was admitted to the Interview with the Ac 10:56am revealed: -She reviewed the re paperwork when he overlooked the follow psychiatrist that was behavioral health ho -She should have ac psychiatrist appointmensure he attended with the psychiatrist. 10A NCAC 13G .090 (c) The facility shall following in the resid (3) written procedur a physician or other and (4) implementation of orders specified in S	with a receptionist with the n 10/04/23 at 1:24pm follow up appointment osychiatrist on 09/22/23. no show for the appointment. lent #2 on 10/04/23 at 1:37pm facility for a month and a see a psychiatrist since he facility. dministrator on 10/04/23 at esident's discharge was admitted but had w up appointment with a scheduled by inpatient spital. ded the resident's nent to the facility calendar to his scheduled appointment 02(c)(3)(4) Health Care 02 Health Care assure documentation of the ent's record: es, treatments or orders from licensed health professional; of procedures, treatments or	C 249	Will ensure that Appointment is w On an appointme Calendar, and that Doctor's office has Correct information Sending out appoint Veminders to ensure	each Witten Pent Pent	
	ivision of He	alth Service Regulation					

Б STATE FORM

6899

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If continuation sheet 12 of 23

Division of Health Service Regulation

AND PLAN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G:	(X3) DATE SURVEY COMPLETED
		FCL046021	B. WING		R 10/04/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE	10/04/2020
STEPHE	INSON FAMILY CARE	HOME 316 EAS	T RICHARD	STREET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
	This Rule is not me Based on observation reviews, the facility implementation of a residents (#2) with of feet in Epson salt at then apply ointment The findings are: Review of Resident 08/09/23 revealed: -Diagnoses included bipolar type, mild int asthma. -The resident was in ambulatory. -There was an order Epson salt at bedtim apply aquaphor ointr Review of Resident a 08/31/23 revealed: -The resident requires toileting and groomir -The resident requires bathing. -The resident receives and was referred for Review of Resident a deministration record revealed: -There was an electro be used to soak feet	et as evidenced by: ons, interviews, and record failed ensure the physician's order for 1 of 3 orders to soak the resident's bedtime for 15 minutes and "#2's current FL-2 dated d schizoaffective disorder cellectual disability, and intermittently disoriented and r to soak the resident's feet in the for 15 minutes and then ment. #2's Resident Register at was admitted on 08/11/23. #2's Care Plan dated ed limited assistance with ng. ed extensive assistance with ed mental health services mental health services.	C 249	The resident's fee being soaked per- doctor's order-so is minutes; warm and epsen salt a the aintment is a after the appoint with the podiate the feet soak is n PRN. The Admin has scheduled future appeintme fer the resident See the podiate for continued for Care.	the water water ind phied next ist wo wistrator a ent to bist

STATE FORM

6899

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If continuation sheet 13 of 23

Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		DENTINOATION NOMBER.	A. BUILDING		COM	PLETED	
		FCL046021	B. WING		10/	R 04/2023	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
STEPHE	NSON FAMILY CARE	HOME 316 EAS	T RICHARD	STREET			
		AHOSKIE	, NC 27910				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BF	(X5) COMPLETE DATE	
C 249	Continued From page	ge 13	C 249				
	-There was no docu were completed or r	umentation the foot soaks refused.					
	2023 revealed: -There was an elect ointment to be appli- both feet for 15 minus scheduled for 8:00p. -There was docume day from 09/01/23 th Review of Resident = 2023 revealed: -There was an electron ointment to be applied both feet for 15 minus scheduled for 8:00pr	entation of administration each hrough 09/27/23. #2's MAR for September ronic entry for Aquaphor ed to at bedtime after soaking utes in epsom salt bath and m. mentation the foot soaks					
	1:58pm revealed: -There was a black of a thin line that began resident's right foot fir- wrapped around the resident had his show substance that forme was exposed above foot. -There was dried, cra- great toenail. -There was dried, cra- second right toe.	dent #2's feet on 10/04/23 at dried substance in the form of n at the inside of the from the arch of his foot that back of his heel; when the es on the black dried ed a line was where his skin where his shoe covered his acking skin around his left acking skin to the right of his ent #2 on 10/04/23 at 1:37pm					
- t	evealed: He had not received been admitted to the lth Service Regulation	foot soaks since he had facility.					

STATE FORM

6899

ZQ8C11

If continuation sheet 14 of 23

Division of Health Service Regulation

I OL HEALIN SERVICE RE		L		
	IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	FCL046021	B. WING		R 10/04/2023
PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	STATE, ZIP CODE	
ENSON FAMILY CARE	HOME 316 EAS		STREET	
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	D BE COMPLETE
-He reported that th out the tub to me" to -The last time the re- was when he was ir -He refused baths a like taking the time for -The Administrator H importance of taking few weeks before he Interview with the Ad 10:56am revealed: -Resident #2 refuse continued to encour the importance of pr -Resident #2 had re application of ointme -She documented w allow her to soak his provide any docume refusals. -She had not notified physician (PCP) that a bath, to get his fee	e facility staff "don't ever bring o soak his feet. esident had his feet soaked n a local hospital. It times because he did not to bathe. nad to remind him of the g baths and he liked to wait a e took a bath. dministrator on 10/04/23 at d to take baths, but she age him and reminded him of racticing good hygiene. fused foot soaks and the ent several times. then the resident refused to a feet but was unable to entation of the resident's d the resident's primary care t he frequently refused to take et soaked a night and have	C 249	has regular fe Soaks, and the Podiotrist has r Changed the fee to as needed. Administrator Continue to er that the resider	et 2 Vaw tsaaks The Will isure isure
Administration 10A NCAC 13G .100 (j) The resident's mar- record (MAR) shall b following: (1) resident's name; (2) name of the med (3) strength and dos medication administer	04 Medication Administration edication administration be accurate and include the ication or treatment order; sage or quantity of ered;	C 342		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA -He reported that th out the tub to me" to -The last time the re- was when he was ir -He refused baths a like taking the time f -The Administrator H importance of taking few weeks before he Interview with the Ad 10:56am revealed: -Resident #2 refuse continued to encour the importance of pr -Resident #2 had re application of ointme -She documented w allow her to soak his provide any docume refusals. -She had not notified physician (PCP) that a bath, to get his fee ointment applied to H 10A NCAC 13G .100 (j) The resident's mare; (2) name of the med (3) strength and dos medication administer (4) instructions for ad	NOF CORRECTION IDENTIFICATION NUMBER: FCL046021 PROVIDER OR SUPPLIER STREET AD ENSON FAMILY CARE HOME 316 EAS' AHOSKIE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 -He reported that the facility staff "don't ever bring out the tub to me" to soak his feet. -The last time the resident had his feet soaked was when he was in a local hospital. -He refused baths at times because he did not like taking the time to bathe. -The Administrator had to remind him of the importance of taking baths and he liked to wait a few weeks before he took a bath. Interview with the Administrator on 10/04/23 at 10:56am revealed: -Resident #2 refused to take baths, but she continued to encourage him and reminded him of the importance of practicing good hygiene. -Resident #2 had refused foot soaks and the application of ointment several times. -She documented when the resident refused to allow her to soak his feet but was unable to provide any documentation of the resident's refusals. -She had not notified the resident's primary care physician (PCP) that he frequently refused to take a bath, to get his feet soaked a night and have ointment applied to his feet. 10A NCAC 13G .1004 (j) Medication Administration 10A NCAC 13G .1004 (j) Medication Administration record (MAR) shall be accurate and include the following: (1) residen	NOF CORRECTION IDENTIFICATION NUMBER: (No. FCL046021 A. BUILDING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, SUMMARY STATEMENT OF DEFICIENCIES 316 EAST RICHARD AHOSKIE, NC 27910 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Continued From page 14 C 249 -He reported that the facility staff "don't ever bring out the tub to me" to soak his feet. C 249 -The last time the resident had his feet soaked was when he was in a local hospital. C 249 -He refused baths at times because he did not like taking the time to bathe. C 249 -The Administrator had to remind him of the importance of taking baths and he liked to wait a few weeks before he took a bath. C 342 Interview with the Administrator on 10/04/23 at 10:56am revealed: -Resident #2 refused to take baths, but she continued to encourage him and reminded him of the importance of practicing good hygiene. -Resident #2 had refused foot soaks and the application of ointrment several times. -She documented when the resident's primary care physician (PCP) that he frequently refused to take a bath, to get his feet soaked a night and have ointrent applied to his feet. C 342 10A NCAC 13G .1004 (Medication Administration record (MAR) shall be accurate and include the following: C 342 10A NCAC 13G .1	NOP CORRECTION In DENTIFICATION NUMBER: A. BUILDING: FCUME FCL046021 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SIMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USE IDENTIFYING INFORMATION) PREFX Continued From page 14 PREFX -The last time the resident had his feet soaked was when he was in a local hospital. C 249 He reported that the facility staff "don't ever bring out the tub to me" to soak his feet. C 249 -The Administrator had to remind him of the importance of taking batis and he liked to wait a few weeks before he took a bath. C 249 Interview with the Administrator on 10/04/23 at 10:56am revealed: C as needed . -Resident #2 refused to take baths, but she continued to encourage him and reminded him of the importance of practicing good hygiene. C as needed . -Resident #2 had refused to take baths, but she continued to encourage him and reminded him of the application of ointment several times. C as needed . -She documented when the resident refused to allow her to soak his feet but was unable to provide any documentation of the resident's primary care physician (PCP) that he frequently refused to take a bath, to get his feet soaked a night and have ointment applied to his feet. C 342 10A NCAC 13G .1004 (Medication Administration Precident's name; (2) name of the medication admininistration record (MAR) shall be accurate and

Division of Health Service Regulation STATE FORM

6899

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If continuation sheet 15 of 23

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AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		FCL046021	B. WING			R 0 4/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
STEPHE	NSON FAMILY CARE	HOME	T RICHARD			
04.0.15	CUBBLADY OTA		, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLE DATE
C 342	Continued From page	ge 15	C 342			
	 (5) reason or justific medications or treat documenting the resi (6) date and time of (7) documentation of medications or treat omission, including (8) name or initials of the medication or treat signature equivalent documented and ma administration record This Rule is not me Based on observation reviews, the facility for medication administ for 1 of 3 residents (used to control psyct The findings are: Review of Resident at 08/09/23 revealed: -Diagnoses included bipolar type, mild into asthma. There was an order antipsychotic medication of schizophrenia). 	 action for the administration of tments as needed (PRN) and sulting effect on the resident; administration; of any omission of ments and the reason for the refusals; and of the person administering eatment. If initials are used, a to those initials is to be aintained with the medication d (MAR). t as evidenced by: ons, interviews, and record ailed to ensure the ration records were accurate #2) who had a medication hotic symptoms. #2's current FL-2 dated schizoaffective disorder ellectual disability, and for Clozapine 200mg to be day at (Clozapine is an ation used to treat symptoms #2's Resident Register 		"The Adminis Will review" Administration in a more + manner so the information Correctly an no information Omitted.	the med 2n recon the throu at all is Apcus	ds 1gh nente
	Review of Resident # 08/09/23 revealed Cl	t was admitted on 08/11/23. #2's physicians order dated ozapine 200mg to be day at 8:00am and 8:00pm.				
	Review of Resident #	#2's medication				

STATE FORM

Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	,
	FCL046021		B. WING		R	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	10/04/2023	i
STEPHE	NSON FAMILY CARE	HOME 316 EAS	T RICHARD S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPL	ETE
	revealed: -There was an entry one tablet two times 8:00am and 8:00pm Clozapine 200mg w 8:00am and 8:00pm -There was no docu 200mg tablet was a 8:00pm, and the M/ -There was no docu 200mg tablet was a 8:00am and 8:00pm -There was no docu 200mg tablet was a 8:00am, and the M/ Review of Resident 2023 revealed: -There was an entry one tablet two times 8:00am and 8:00pm that Clozapine 200m 8:00am and 8:00pm that Clozapine 200m 8:00am and 8:00pm -There was no docu 200mg tablet was at 0 09/09/23 at 8:00p blank. Telephone interview facility's contracted p 3:08pm revealed: -Resident #2 Clozap dispensed every weat tablets on 08/21/23. -Clozapine helped co delusions, and disor	rd (MAR) for August 2023 y for Clozapine 200mg, take a day for schizophrenia at h, there was documentation vas to be administered at h. umentation that Clozapine dministered on 08/29/23 at AR was left blank. umentation that Clozapine dministered on 08/30/23 at h, and the MAR was left blank. umentation that Clozapine dministered on 08/31/23 at AR was left blank. #2's MAR for September for Clozapine 200mg, take a day for schizophrenia at h, there was documentation ng was to be administered at mentation that Clozapine dministered on from 09/06/23 m, and the MAR was left with a pharmacist from the oharmacy on 10/04/23 at here 200mg prescription was lek for a 7 day supply of 14 ontrol hallucinations,	C 342			

STATE FORM

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CLE CONSTRUCTION	COMF	SURVEY PLETED
		FCL046021	B. WING		1	२)4/2023
	(EACH DEFICIENCY	HOME 316 EAS	DRESS, CITY, T RICHARD E, NC 27910 ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
C 342	-She forgot to docu Clozapine 200mg tw resident's MAR. -Resident #2 did no was her mistake no administration of his resident's MAR. -She should not hav blank, she should he time the medication -It was her responsi correct documentati medications on the Attempted telephony primary care provide 3:28pm was unsucc 10A NCAC 13G .100 (a) A family care ho retrievable record of documenting the rec disposition of contro records shall be mai record and in such a accurate reconciliati This Rule is not me Based on observatio interviews, the facilit the receipt and adm substances were mai	ment the administration of vo times a day on the t refuse his medications and it t to properly document the s Clozapine 200mg on the ve left Resident #2's MAR ave placed her initials each was administered. bility to ensure there was ion of administration of MAR. e interview with Resident #2's er (PCP) on 10/04/23 at cessful. 08(a) Controlled Substances one shall assure a readily i controlled Substances one shall assure a readily i controlled substances by ceipt, administration and illed substances. These intained with the resident's an order that there can be on.	C 342	The Adminis Will review Medication Records in a through man that all info is decument. and that no is omitted.	the Adminin a more ner so mer so ormation red corre	ctly

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Division of Health Service Regulation

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
		FCL046021	B. WING			R / 04/2023
	PROVIDER OR SUPPLIER	216 EAG	DDRESS, CITY, S			
STEPHE	INSON FAMILY CARE		E, NC 27910			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	IN SHOULD BE	(X5) COMPLE DATE
	Review of Resident 01/31/23 revealed of schizophrenia, mild neurocognitive diso Review of Resident 06/05/23 revealed L administered twice of Observation of med #3 on 10/04/23 at 1° -There were 2 cards available for Reside 09/08/23 for a total of cards (30 tablets ea -There were 4 doses total of 8 doses. Review of Resident administered twice of -There was an entry administered twice of -There was docume was administered ea 8:00pm on 08/01/23 Review of Resident (CS) log for August 2 -There were 2 CS lo labeled for Lorazepa twice daily with a qua dispensed on 08/08/ designated for "am" -There was docume doses were available	 #3's current FL-2 dated liagnoses included intellectual disability and rder. #3's physician's order dated orazepam 0.5mg was to be daily. ications on hand for Resident 1:55pm revealed: s of Lorazepam 0.5mg nt #3 with a dispense date of quantity of 60 tablets in 2 ch). s remaining in each card for a #3's medication d for August 2023 revealed: Lorazepam 0.5mg to be laily. ntation Lorazepam 0.5mg ach day at 8:00am and through 08/31/23. #3's Controlled Substance 2023 revealed: g sheets for Resident #1 im 0.5mg to be administered antity of 62 that was 23; one sheet was and the other for "pm". ntation on each sheet that 60 e beginning on 08/08/23. 	C 367			

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		FCL046021	B. WING		R 10/04/2023
	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	10/04/2023
	ISON FAMILY CARE	HOME	, NC 27910		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE COMPLETE
	remaining. Review of Resident administration recor revealed: -There was an entry administered twice of -There was docume was administered ea 8:00pm on 09/01/23 Review of Resident administration record -There was an entry administered twice of -There was docume was administered ea 8:00pm on 10/01/23 8:00pm on 10/01/23 8:00pm on 10/04/23 Review of Resident a 2023 revealed: -There were 2 CS lo abeled for Lorazepa wice daily with a qua dispensed on 09/08/ designated for "am" -There was documer abeled for Lorazepa wice daily with a qua dispensed on 09/08/ designated for "am" -There was documer doses were available -There was documer administered each di hrough 10/04/23 wit	day at 8:00pm from a 09/06/23 with 30 doses #3's medication d for September 2023 Lorazepam 0.5mg to be daily. ntation Lorazepam 0.5mg ach day at 8:00am and though 09/30/23. #3's medication d for October 2023 revealed: Lorazepam 0.5mg to be laily. ntation Lorazepam 0.5mg ach day at 8:00am and though 10/03/23 and at #3's CS log for September g sheets for Resident #3 m 0.5mg to be administered antity of 60 that was	C 367	The Administrat Continue to the review and mon Control substan Medications and To ensure that No Medications	nitor ce 1 Logs. t there

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		SURVEY
						R
		FCL046021 B. WING			04/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
STEPHE	NSON FAMILY CARE					
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	E, NC 27910	PROVIDER'S PLAN OF CO	ODDEOTION	
PRÉFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
C 367	Continued From pa	ge 20	C 367			
C935	3:08pm revealed: -A 31 day supply of 0.5mg were dispens 08/01/23 to begin of -A 30 day supply of 0.5mg were dispens 09/01/23 to begin of -The quantity of tabl dispensing cards, of dose, and a CS log Interview with the Ad 4:26pm revealed: -Resident #3 was ac 0.5mg twice daily. -New medication ba each month and eac 8th of the month. -She started in the w August 2023 and wa started the log when began. -She expected contr counted daily and re and the CS sheet.	62 tablets of Lorazepam sed for Resident #3 on n 08/08/23. 60 tablets of Lorazepam sed for Resident #3 on n 09/08/23. lets were split evenly into 2 ne for am and one for pm sheet was sent for each card. dministrator on 10/04/23 at dministered Lorazepam tches came to the facility ch batch started around the vrong column on the CS log in as not being careful when she the new medication packs flect accurately on the MAR hy the count of medications ch the CS log.) ACH Medication	C935			
	G.S. § 131D-4.5B (b) Adult Care Home aining and Competency				
	home is prohibited fr any unsupervised me	er 1, 2013, an adult care om allowing staff to perform edication aide duties unless eviously worked as a				

STATE FORM

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		FCL046021	B. WING		R 10/04/2023
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
STEPHE	NSON FAMILY CARE	HOME 316 EAST	RICHARD	STREET	
		AHOSKIE	NC 27910	ł	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLE
C935	medication aide dur an adult care home of the following: (1) A five-hour trainin Department that incl in all of the following a. The key principles administration. b. The federal Cente Prevention guideline applicable, safe injec procedures for moni bleeding occurs or th exists. (2) A clinical skills ex NCAC 13F .0503 an (3) Within 60 days fr individual must have a. An additional 10-h developed by the De training and instruction 1. The key principles administration. 2. The federal Cente Prevention guideline	ing the previous 24 months in or successfully completed all ing program developed by the ludes training and instruction is of medication ers for Disease Control and is on infection control and, if ction practices and toring or testing in which he potential for bleeding valuation consistent with 10A d 10A NCAC 13G .0503. om the date of hire, the completed the following: nour training program spartment that includes on in all of the following: of medication rs of Disease Control and s on infection control and, if	C935	The Administ Will Choure Cach Staff u have successfe passed the s Medication of Cays of Con the lo-hour aide training- have validate their medica	that ill ully tate a 1 de a 1 de npleting medication Will ion of ation
	bleeding occurs or the exists.	toring or testing in which ne potential for bleeding		Com petency Ch	ecklist n of the
	by the Division of He	eveloped and administered alth Service Regulation in section (c) of this section.		Competency Ch and completion five hour med training program	ication
	facility failed to ensur aides (Staff B) had si medication aide exar	and record reviews, the re 1 of 2 sampled medication uccessfully passed the state			

STATE FORM

6899

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If continuation sheet 22 of 23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	Follower				R
		FCL046021	B. WING		10/04/2023
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
STEPHE	NSON FAMILY CARE		RICHARD	STREET	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
C935	Continued From page	ge 22	C935		
	competency checkli	ompletion of the five hour			
	Review of Staff B's r personnel file reveal -She was hired on 0 -She completed the 10/06/20. -She completed the competency checklis -There was no docur the state MA exam. -There was no docur completing the 5-hou Interview with the Ad 5:00pm revealed: -Staff B had taken th not know why there w personnel record. -She should have a d exam in her personnel -Staff B passed med	4/17/22. 10-hour MA training on medication administration st on 05/20/22. mentation of Staff B taking mentation of Staff B ur MA training. ministrator on 10/04/23 at state MA exam and she did was not a record in her copy of Staff B's state MA			

Division of Health Service F STATE FORM

6899

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If continuation sheet 23 of 23